
Piloting Körner

The views of senior administrators from the four districts who piloted the interim reports of Working Groups A to E from 1981 to 1983

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the King's Fund of behalf of the NHS/DHSS
Health Services Information Steering Group

Piloting Körner is the fourth of a series of occasional papers produced by the NHS/DHSS Health Services Information Steering Group and published on its behalf by the King's Fund. The other titles in this series are

Converting data into information: proposals formulated by members of two workshops held in March 1982 about the management arrangements required for collecting valid clinical data and providing a district information service

Introducing IT in the district office: proposals arising from a study carried out in Southend Health District by Aslib Research and Consultancy in 1982

Developing a district IT policy: proposals formulated by members of a workshop held in June 1983 about the development of a district policy for the introduction of information technology with particular emphasis on the implementation of computerised departmental information systems

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Published by the King's Fund on behalf of the
NHS/DHSS Health Services Information Steering Group

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'On few matters in life is the gap so great as between a dry antiseptic statement of a policy by a well-spoken person in a quiet office and what happens when it is put into practice.'

J K Galbraith, *The Age of Uncertainty*

Preface

The central task of the Information Steering Group is to propose data which are to be collected about the work of the NHS to assist policy makers and managers. One of the obvious dangers of this task is that wishful thinking clouds the judgment about what it is feasible to collect, particularly if the data are to be strictly comparable and the effort of collecting them commensurate with their potential usefulness.

It therefore seems important to test the assumptions about feasibility made by working groups in interim reports against the day to day reality of the work place.

We were fortunate to find — at a time when the NHS was being re-structured, ministerial reviews introduced and manifold other new pressures experienced — four NHS health districts who shared our motivation and were willing to add to their onerous duties by acting as a test bed for our proposals.

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The present publication, the fourth in a series, briefly outlines how the piloting was carried out, and it is only between the lines that the disciplined effort to carry out the task can be discerned. It also gives some idea of the considerable contribution which the four districts made to our thinking. Beyond the inherent interest of the present exercise, conclusions may be drawn about the general concept of piloting proposals before they are implemented and about the techniques which may be appropriate for this.

The Information Steering Group wishes to record its thanks to all the staff in the four districts who so effectively participated in the capture, collection and coding of data. Without exception they carried out this work diligently and competently in addition to dealing with existing information requirements. The pilot coordinator, Lorna Wainwright, has provided the important link between the working groups and the pilot districts and has contributed greatly to the smooth running of the trials.

Our very special thanks go to the authors of this document, Philip Chubb, Michael Court, Alan Dickinson and Henry Foster. They worked and continue to work indefatigably and bear cheerfully the burden of structuring, administering and collating the work. They have offered us much constructive criticism and valuable suggestions both about the conduct of the piloting and about the proposals being piloted. Without them we could not have hoped to succeed.

Edith Körner

Chairman Health Services Information Steering Group

Chapter 1 : Review of data content

Introduction

- 1.1 Over the next three to five years all health authorities will be implementing the recommendations of the NHS/DHSS Steering Group on Health Services Information. The proposals about the data content of management information systems have gained wide acceptance within the NHS and the philosophy and principles underlying the data sets are relevant to the current needs of NHS managers.
- 1.2 The review of NHS management information systems has been carried out by setting up a series of working groups, each reviewing a particular area of work. To date, the following working groups have been set up:
- A. Hospital facilities used by consultant medical staff
 - B. Laboratory and scientific services
 - C. Paramedical services
 - D. Community health services
 - E. Health service manpower
 - F. Health service management accounting
 - G. Patient transport services
 - H. Miscellaneous, completing the work of the other groups.

Methods of working

- 1.3 All the working groups work in a similar fashion, namely:

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- a. identification of the information requirements of a district health authority and its management team;
- b. identification of any additional needs of regional authorities and central government departments (primarily the DHSS and OPCS);
- c. development of definitions and classifications for the data items which are to be collected to satisfy identified requirements;
- d. field testing of the recommendations in at least four health districts;
- e. consultation about the recommendations, both formal by the circulation of working papers and interim versions of recommendations, and informal through a series of regional seminars; and
- f. finalising recommendations in the light of field testing and consultations, and indicating the likely resource consequences and a feasible timetable for implementation.

1.4 The first step is to identify the information requirements of a district health authority and its management team. This has not involved the development of a theoretical model but has been achieved by using the extensive practical experience of those NHS managers who are well known for their innovative use of information. Members of the working groups discuss their work in progress with colleagues throughout the NHS; none of the deliberations of the Steering Group or its working groups are secret.

1.5 Once the first stage has been completed, the working groups are supplemented by representatives from the regional health authorities and central government who have to justify any additional information requirements of these higher tiers. There have been few cases to date where such demands have been conceded and these were due to legislative requirements.

1.6 Having identified the information required, detailed work starts on developing definitions and classifications for the data items which will need to be collected. Once this time consuming and

painstaking work has been completed, an interim report is released by the Steering Group for consultation and piloting.

- 1.7 The Steering Group has given considerable thought to the best ways of obtaining the views and support of the large number of staff working in the NHS. In addition to the traditional method of writing to the administrator of each health authority and the relevant professional organisations, a nationwide marketing campaign is mounted. By arranging a series of day seminars around the country at which those responsible for the interim reports present their findings, not only is a better understanding of the work achieved but also valuable criticisms have been made which influence the content and format of the final reports. Over 1500 people attended the seminars which preceded the preparation of the First Report of the Steering Group to the Secretary of State.

Piloting

- 1.8 One of the most refreshing features of the Steering Group's method of working is the field testing or piloting of any new data items, definitions or classifications recommended in the interim reports. The four pilot districts have learnt a lot, not only about data content but also about the dynamics of information collection and the crucially important training and reorientation task that faces authorities when they come to implement the new information systems. The implications of the piloting experience for implementation are discussed in Chapter 4.
- 1.9 The piloting studies have contributed greatly to the credibility of the Steering Group's recommendations and much interest has been expressed in their conduct and findings. Chapter 2 describes the pilot districts, the administrative arrangements and relationships both nationally and in the district, and the methods of working.

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1.10 Although the piloting has now been completed for the interim recommendations of Working Groups A to E, this paper is concerned mainly with the experience of piloting the findings of Working Groups A and B. The results of these studies are discussed in Chapter 3 and were an important ingredient in the preparation of the First Report which was published in September 1982.

Chapter 2 : The piloting studies

The districts

2.1 The field testing is carried out primarily in four districts:

- a. Exeter,
- b. Herefordshire,
- c. North Tees, and
- d. South Birmingham.

The four districts involved vary considerably in size, facilities and their previous experience and expertise in handling information.

2.2 Exeter has 31 hospitals spread over a wide geographical area and serving a population of nearly 300 000. There are nine radiology departments. The district has a nationally recognised reputation for the innovative use of information and was the site of one of the first DHSS experimental computer projects.

2.3 Herefordshire is a self-contained district providing a complete range of services to more than 95 per cent of its resident population of about 150 000. The district general hospital is split over four sites in the town. Ten other smaller hospital sites are located in various market towns in the district. Prior to piloting, attempts had been made to develop an information system linking workload, manpower and financial information.

2.4 North Tees is a district with one hospital site serving a compact area with a population of about 200 000. The district has considerable experience and expertise in using microcomputers and was involved in the specialty costing trials organised by the DHSS.

2.5 South Birmingham is one of five health districts serving a major conurbation with large patient flows between the districts. A full range of services is provided, including some regional specialties, from ten hospital sites. The district has been developing a community services financial system as part of the Financial Information Project sponsored by the DHSS and the West Midlands Regional Health Authority.

Administrative arrangements

2.6 The piloting is supervised by the Feasibility Study Steering Group which was chaired until July 1983 by the District Administrator of South Birmingham. The membership and terms of reference of the Group are shown in Appendix A. The day to day contact between the Steering Group and the pilot districts is maintained by the Coordinator of the pilot studies. The Coordinator, with a detailed knowledge of the recommendations and the reasoning behind them, provides invaluable assistance to the districts while piloting is being planned and carried out.

Working methods

2.7 The prime aim of piloting is to test the feasibility of capturing, collecting and coding the data items recommended in the interim reports. It is not possible nor necessary to pilot all the recommendations, some of which are data items with associated definitions which have been collected in the NHS for many years. The Feasibility Study Steering Group is responsible for deciding which data items need piloting, how it should be done and for how long. In practice all new data items, definitions and classifications are piloted. As the districts still have to collect the currently required statistical returns, an important factor has been to find ways of minimising the additional work required by piloting.

2.8 For each interim report a protocol and management checklist is developed, detailing the items to be covered by piloting. Model forms have been required to collect some data items and examples of these are in Appendix B.

2.9 The arrangements made in each district for piloting have general relevance as they highlight the problems to be avoided when the new data sets are introduced in all districts. In theory the process is straightforward and should be as follows:

- a. the recommendations need to be discussed and explained to all concerned, particularly those responsible for collecting data;
- b. methods of collection need to be agreed and instituted;
- c. instruction manuals and forms need to be drafted and circulated;
- and
- d. target dates for data returns and reports need to be established.

In practice, of course, numerous difficulties and problems occur. Those which arose during the piloting of the recommendations of Working Groups A and B are discussed in Chapter 3.

2.10 At the end of each trial, all the districts produce a report covering the points in the management checklist and the trial protocol. After discussion, a combined report is drafted drawing together the similarities and differences between the districts. The composite reports are presented to the Feasibility Study Steering Group for onward transmission to the drafters of the final report. When a final report is submitted to the main Steering Group for approval, copies of the districts' report on piloting are available separately. The First Final Report took full account of the piloting experience and contained modifications and developments of the original proposals in the interim reports of Working Groups A and B.

2.11 Although the administrative arrangements were set up to

maintain the independence of the districts from working group members, it has been inevitable that the two parties have influenced each other. Throughout piloting there has been a creative tension which, on the whole, has been mutually educative and to the benefit of the final product, the reports to the Secretary of State. However, there have been occasional difficulties within the districts when the reasons for collecting a data item were not understood or accepted or particular concepts were being pushed too enthusiastically by working group members.

Chapter 3 : Working groups A and B

3.1 The recommendations in the interim report of Working Group A were piloted during November and December 1981, and those in the report of Working Group B in September and October 1981. The radiology and pathology piloting was a relatively straightforward task but the piloting of the recommendations of Working Group A, covering as they did the major clinical areas in the hospital, was complex and difficult.

Working Group A

3.2 The major problems of carrying out the piloting of the recommendations of Working Group A were:

- a. the volume of training and education required,
- b. the running of duplicate systems, and
- c. the interpretation of the new definitions.

3.3 The collection of clinical activity data involves clerical staff and health professionals. Explaining the piloting requirements to all the staff involved was a major educational and training task. This was made more difficult in the piloting exercise by the late arrival of the piloting forms due to delays in agreeing their content; a problem familiar to all those who have introduced new procedures in the NHS. Staff responsible for overseeing piloting also had difficulty in explaining the requirements to data collectors, particularly when they were unsure themselves what was required or had legitimate doubts about the need for certain data.

3.4 The magnitude and complexity of the training task was obviously influenced to a large extent by the medical records organisation in

the district, and the quality and quantity of existing systems and staffing. In the districts with a district medical records officer with executive responsibility for the records service in all the hospitals, the task was less difficult for district managers than in the others where medical records officers have responsibilities limited to individual or small groups of hospitals. In the latter districts, administrators and nursing officers with responsibilities for the collection and compilation of statistical data had to be approached directly by district management.

3.5 The current NHS returns about hospital activity had to be collected as well as the data being piloted. Running two systems with similar data being collected but with different definitions obviously raised difficulties. A glossary of the new terms and definitions was available in all districts and was of undoubted value. However, it was not possible to check that these were used by all data collectors.

3.6 A cardinal principle laid down by the Feasibility Study Steering Group was that the new statistics should reflect reality and items should not be forced into a certain category if they did not fit with the recommended definitions and classifications. A 'difficulty diary' was kept by medical records officers listing the problems which occurred. Many of these had little to do with the new data but related to existing problems and difficulties. However, there were a number of definitional problems thrown up by piloting. For example, was the aim to record activity within the district, or activity carried out by staff working mainly in the district? This is of particular relevance to outpatient clinics held by consultants based in the district but taking place on a site in another district.

3.7 The recommendations in the interim report of Working Group A comprised:

Working groups A and B/15

- a. the minimum data set for a patient using a hospital bed,
- b. the content of inventories of hospital facilities,
- c. data required about the availability and use of clinical facilities, and
- d. data about the unmet demand for outpatient care and hospital beds.

3.8 The minimum data set for a patient using a hospital bed proved relatively straightforward to collect except for the postcode. Only about 30 per cent of patients admitted to one of the district general hospitals could give a postcode. Whilst acknowledging the value of this data item, the collection of postcodes is likely to prove time consuming until more people are familiar with their code and use it, or the automatic computer coding of addresses becomes generally available.

3.9 No problems arose in collecting data on transfers between consultants, wards and hospitals. Difficulties arose, however, in identifying when a patient is cared for jointly by two or more consultants as opposed to a second opinion being sought or responsibility being transferred. In the First Final Report, the Steering Group recommended that further work is required to clarify this difficult point.

3.10 The inventories of facilities proved relatively straightforward to complete. Some problems were experienced in identifying and classifying wards and these have been resolved by the recommendations of the Final Report. While compiling the inventories, two of the districts discovered that the bed complements being used were inaccurate; in one hospital the complement was recorded as being greater than it had been for over a decade. The inventories involved relatively few staff members and were easily validated by other existing information or local knowledge.

3.11 The inventory of outpatient clinics revealed a number of clinics

which were not included in the current SH3 statistics. The limitations of using session as the unit for resource, which was recognised by Working Group A, was also highlighted during piloting. Crude figures about the number of planned sessions can hide very different work patterns. The number and type of doctors working in an outpatient clinic will have a profound effect on the number of patients who can be seen and the resources used.

3.12 With the exception of the recommendations about outpatient clinic activity, it proved feasible to collect the requisite data about the availability and use of clinical facilities. The threefold categorisation of outpatient attenders proved difficult to collect in the way proposed and the level of accuracy was felt to be low. The piloting findings were confirmed during consultation and the Final Report recommendation reverts to a two point classification – namely, referrals and consultant initiated.

3.13 Problems were experienced in collecting data about the unmet demand for outpatient clinics because of factors like oral referrals and the dissemination throughout the hospital of referral letters. Modifications to the original recommendations have been made in the Final Report.

3.14 Data about the unmet demand for elective admissions proved to be collectable, but the analysis of the data was time consuming. Those districts who did not hold these data centrally found this exercise involved a considerable training and communications effort. The computerised approach advocated in the Final Report would have considerable advantages in cutting down the manual work required, but was not recommended as a minimum requirement.

Working Group B

- 3.15 Three main problems were identified in setting up the trials for the Working Group B recommendations, namely:
- a. Negotiations at Whitley Council level to obtain the agreement of functional councils to allow staff to participate in the pilot trials. Because local agreement could not be reached, one laboratory department did not participate in the trial.
 - b. The lack of clerical support, particularly in small radiology departments.
 - c. Difficulties in gaining access to data for analysis at a time which did not interfere with routine work.
- 3.16 Apart from the industrial relations problem in one district, none of the others were insoluble. The number of staff involved was small and only a few data items had to be collected.
- 3.17 The collection of the data items in the radiology recommendations was not difficult. There were some detailed enquiries about the categorisation of the procedures and how different combinations of examinations should be scored. These points have been incorporated in the Schedules in the Final Report. The only problem in implementing these proposals will be for departments without clerical help because the analysis of these data into the required categories is time consuming.
- 3.18 For pathology two options were piloted. Two districts analysed all requests by referring consultant, whilst two carried out a sample analysis of specific tests by consultants. Both options proved feasible. During piloting some problems arose over the definition of a request and this has been amended in the First Report.
- 3.19 The Steering Group has recommended the option involving the

analysis of all requests. In large chemical pathology or haematology departments the effective implementation of this recommendation will require computer support because of the large volume of data to be processed. If this is done in a non-automated system it may be necessary, for the time being, to analyse requests for sample time periods rather than continuously.

Chapter 4 : Implications of piloting

4.1 During the course of piloting it has become clear that the work of the NHS/DHSS Steering Group on Health Services Information has implications at national and local levels.

National level

4.2 At national level, the way that the Steering Group has conducted its business highlights the need for:

- a. getting commitment from the NHS for change,
- b. field testing policy proposals, and
- c. allowing for local flexibility.

4.3 If the Steering Group continues to enjoy NHS support, it is likely that this style of joint NHS/DHSS group with a NHS chairman could become the norm for major policy reviews. The 'Körner approach' with its emphasis on wider and in-depth consultation, and actually altering recommendations in response to well argued views, leads to greater commitment to change and should ease the course of implementation.

4.4 When dealing with a technical area such as health service information and a review as comprehensive and important as that carried out by the Steering Group, the field testing of recommendations is essential. This approach could be adopted with advantage in other policy making areas by the DHSS and the special health authorities.

4.5 One of the most attractive components of the Steering Group's

philosophy is the flexibility allowed by determining a requisite minimum national requirement with encouragement to each district to collect more data for its own purposes. No doubt some authorities will consider the minimum the maximum, but the setting of minimum standards is a much healthier approach than trying to force authorities to go into detail which does not involve or concern them.

District level

4.6 At the local level the piloting experience has highlighted the fact that insufficient attention has been given by senior district management to data collection and processing and, in particular, to the work of the medical records function. Piloting has given district managers the opportunity to find out what is actually happening in the hospital. In many cases the conditions under which data are currently collected came as a surprise. There were major problems for medical records staff in terms of their buildings, equipment, working conditions and staffing levels. Many of the diagnostic departments and small hospitals had inadequate or non-existent clerical support and data collection systems.

4.7 The introduction of the Steering Group's recommendations will inevitably lead to a major district review of how, where and when data are collected and a consideration of the organisation and levels of staffing required. Good data collection requires:

- a. workable management arrangements,
- b. effective training of all data collectors,
- c. efficient data collection systems,
- d. arrangements for ensuring data quality, and
- e. appropriate information technology.

The observations that follow are drawn from the piloting of the recommendations about hospital clinical activity data.

4.8 Central to the *management arrangements* for the collection of clinical activity data is the role of the medical records officer. In the rapid growth of functional management since the 1970s, the medical records function has been underplayed in relation to the gradings available and responsibilities undertaken, although the expertise and authority required to run clinical activity data collection systems are now widely acknowledged.

4.9 Obviously there are small hospitals where it is inappropriate to have full-time medical records staff. However, the staff who carry out data collection in these situations must be trained and supervised and this is particularly important when existing patterns of work change. Regardless of who has managerial responsibility for such staff, the medical records officer must be closely involved in training and monitoring standards. The complexities of such a task must be reflected in the grading and salary offered. The increase in the levels of grading for unit administrators should create the possibility for the role of the medical records officer to be appropriately recognised without impinging on the levels of grading of line administrators.

4.10 The major task of implementation will be the *training* of all the collectors of clinical activity data. Training should not be limited only to staff employed in the medical records function but must extend to many other hospital staff. These include:

- a. night duty nurses responsible for completing the daily ward listing which will replace the midnight bed return;
- b. nurses in charge of a ward during the day who have to identify regular day admissions and ward attenders;
- c. staff in pathology and radiology;
- d. outpatient clinic clerks and nurses;
- e. operating theatre staff; and
- f. staff in NHS day care facilities.

- 4.11 The Steering Group has set up a training advisory group which is producing training packages for all the minimum data sets recommended in the final reports. The centre piece of each package will be a computer based learning program which will run on the BBC Microcomputer B. While regional training departments will have a role to play in ensuring training arrangements are made in each district, the main task of training will fall to line managers in the hospital.
- 4.12 Many medical records departments have functioned for years without any formal training of staff, and new staff learn from watching colleagues. Nurses and other health professionals who collect clinical activity data are rarely instructed in these important tasks. The implementation of the Steering Group's proposals will provide a stimulus not only to training for the implementation of the new system but also to the continued training and development of data collectors. This has proved to be the case in the pilot districts.
- 4.13 The importance of well planned *data collection systems* was highlighted during the pilot trials. Good form design is an essential prerequisite to accurate data capture and this skill is underrated in the NHS. The intention of the Steering Group to provide model forms as part of the nationally developed training packages is welcome. These must be available well before any new system is implemented so that staff can become familiar with the new form and any problems about layout or definitions can be resolved before it comes into use.
- 4.14 With the introduction of the new data systems it will be essential to make arrangements for ensuring *data quality*. To achieve compliance and consistency throughout the district, monitoring systems will have to be set up. The need for such arrangements are stressed in the publication, *Converting data into information* where

it is held that the expertise to monitor standards of clinical activity data content, completeness and timeliness lies in the medical records discipline.

- 4.15 The most pressing need and the area in which considerable investment will be required is the acceleration of a district *information technology* (IT) capability. This would have been necessary even if the Steering Group had not carried out its review of data content. For example, accurate, complete information about bed use and the patients using them can only be produced in the timescale required by operational managers by means of a computerised information system.
- 4.16 Likewise the volume of data to be analysed for pathology and radiology requires the use of computerised systems. The rapid and widespread introduction of microcomputing facilities for data analysis in these departments is essential if the recommended data sets, which are readily collectable, are to be converted into information which aids management.
- 4.17 The development of computer systems in the NHS has not been a success story. The opportunity and challenge now posed by the imminent implementation of the new data sets provides the chance to improve on past performance. The recent collaborations between the Health Services Information Steering Group and the NHS Computer Policy Committee augur well for the future. However, the introduction and use of IT in the NHS now seriously lags behind other industries of comparative size and importance in this country and the health services of other countries.
- 4.18 There is an urgent need for IT applications with the capability of providing robust operational systems and producing high quality management information which can be accessed by the non-

technical user. Such applications should be flexible so that they can be tailored to the needs of a particular district.

4.19 The implementation of new data sets, improved training and organisation of data collectors and the introduction of appropriate IT will be of little benefit if the information produced is not used. Few senior managers in the NHS have been trained or encouraged to exploit information in their management activities. The use of information and the knowledge within the organisation that it is being used are the most important factors in ensuring high standards of data accuracy, timeliness and completeness. The education of managers in information use has been given a high priority by the Steering Group and in this task they will need the full-hearted support of the new NHS Training Health Authority.

Appendix A

THE FEASIBILITY STUDY STEERING GROUP

Terms of Reference

1. To test the feasibility of the collection of specific items in the data sets recommended in the interim reports.
2. To test the mechanics for the collection of data.
3. To test the understanding and general acceptance of the definitions and terms used.

Membership

The following were members of the Steering Group during the piloting of the recommendations of Working Groups A and B. The posts are those which were held at the time.

Chairman: Philip Chubb, District Administrator, South Birmingham HD

Secretary: *Lorna Wainwright, Pilot Coordinator

Members:

*Patricia Annesley, Statistician, DHSS

*John Ashley, Senior Medical Officer, OPCS

*Kevin Cottrell, Regional Statistician, North Western RHA

Michael Court, Assistant District Administrator, Exeter HD

Alan Dickinson, Assistant District Administrator, Hereford HD

+Michael Dunning, ISG Secretariat

Henry Foster, District Administrator, North Tees HD

+Graham Guest, RMSO, Wessex RHA

Tony Rowntree, Chief Statistician, DHSS

*Alastair Mason, ISG Secretariat

Michael Slattery, Regional Statistician, Wessex RHA

*Member of Working Group A

+Member of Working Group B

Appendix B

FORMS USED FOR PILOTING

1. A small group of members drawn from Working Group A and including the Coordinator was set up to design the piloting forms. The districts had different data collection systems and the piloting forms had to be compatible with the local documentation.
2. The 'difficulty diaries' kept by each medical records officer highlighted ambiguities in the terms used on the forms and those items which were difficult to collect. The form design group reviewed the problems identified and provided a technical report for the Steering Group which was invaluable to the preparation of the First Report.
3. Examples of the forms used for recording day care facility and operating theatre activity are illustrated. These forms were specially designed for the piloting trial and have been amended since. Model forms for the collection of all the clinical activity data recommendations in the First Report are being prepared by the Steering Group's Training Advisory Group.

REGULAR DAY CARE - AVAILABILITY AND USE OF FACILITIES

K4

For the Month ending:-.....DISTRICT

**HOSPITAL
CENTRE**

SPECIALTY AND FUNCTION	NUMBER OF PLACE-DAYS WHICH WERE AVAILABLE	REGULAR DAY ATTENDERS			PATIENTS ALSO USING A HOSPITAL BED		
		FIRST ATTENDANCES	TOTAL ATTENDANCES	ON REGISTER AT END OF PERIOD	FIRST ATTENDANCES	TOTAL ATTENDANCES	ON REGISTER AT END OF PERIOD
GERIATRIC MEDICINE							
MENTAL ILLNESS Psychogeriatrics							
MENTAL ILLNESS Other							
MENTAL HANDICAP							
Younger Disabled							
OTHERS (Please Specify)							
TOTAL							

OPERATING THEATRE - AVAILABILITY AND USE OF SESSIONS

K3

For the Month ending:-.....

..... DISTRICT

..... HOSPITAL

SPECIALTY	ROUTINE THEATRE SESSIONS		CASES OPERATED ON	
	HELD	CANCELLED	IN ROUTINE SESSIONS	OUTSIDE ROUTINE SESSIONS
GENERAL SURGERY				
E.N.T.				
OPHTHALMOLOGY				
ORTHOPAEDICS				
PLASTIC SURGERY				
UROLOGY				
NEUROSURGERY				
DENTAL SURGERY				
OBSTETRICS & GYNAECOLOGY				
OTHERS (Please Specify)				
TOTALS				

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