BMJ

BMJ 2012;344:e4141 doi: 10.1136/bmj.e4141 (Published 18 June 2012)

LETTERS

NHS DATA IN THE TIME OF REFORM

Authors' reply to Soljak

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Soljak seems not to understand how the Health and Social Care Act 2012 will limit the availability of routine data to monitor the health service and the population by abolishing area based structures and transferring most health service responsibilities to non-geographically based clinical commissioning groups.[1] Neighbourhood statistics and the index of multiple deprivation (IMD) increasingly draw on a range of more timely population based administrative and survey data,[2] but even this fuller range of data and readily available tables to convert postcodes to output areas and IMD scores cannot compensate for variation in output areas and the potential for practices to cherry pick the healthiest and wealthiest patients from more deprived output areas.

Average list inflation is not only around 5% but varies by up to 30% in some primary care trusts.[3] Also, in Manchester only 78% of names and addresses held on general practice registers can be matched with equivalent records held on the council tax system.[4]

The developments in using data from general practice systems are not new datasets and do not supersede data collections that have been lost or have deteriorated after cuts to the NHS and Office for National Statistics.

General practices might provide more up to date data than the census, but these data will be seriously incomplete in respect of the residents living in an area. Moreover, data will be recorded only when people register and will be updated only when they consult, with data missing or out of date for those who do not consult.

The ethnicity study in Scotland is irrelevant as South Asian ethnicity was identified retrospectively from surnames rather than being self-reported.

That general practice and hospital systems all use classifications based on ICD-10 is no guarantee that the ICD codes will be allocated or derived in the same way.[5]

The switch from contiguous administrative areas to a system in which nobody has ultimate responsibility for monitoring and meeting the healthcare needs of all residents and in which general practices are incentivised not to take on high risk patients means that those who do not receive care will no longer be counted or measured, as in low income countries.[6 7]

Competing interests: None declared.

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Cite this as: *BMJ* 2012;344:e4141

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