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 recenty 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,

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while hospital consultants will be coded by GMC code number.

The location of patient residences will be by postcode but full addresses will also be needed; the purchaser and provider organisations will be coded by unique five character codes and these will be combined together with a further six character code to identify specific contracts.

The adoption of these coding systems will need major changes to all existing systems which are not at present designed to cope with other than local coding needs.

While concentrating on patient contacts, the report does move on to discuss the information requirements for medical audit and emphasises the importance of ensuring that audit systems have the ability to progress to interact with patient-provider systems both in terms of consistent data sets and the ability to physically transfer data. Issues such as use of postcodes and consistent clinical coding systems are seen to be of great importance and the report suggests close links between local audit initiatives and work being undertaken centrally by resource management teams at the DoH.

This view is reflected later in the report when discussing organisational structures and emphasises that individuals must recognise that creating an information island outside the framework of agreed standards not only cuts off the individual from others but also denies to others data which they might wish to utilise.

The work on medical audit is closely tied to development of measures of outcome and quality of care; because of the small number of established measures available these have not been included in the data sets for provider or contract areas but a project is to be set up to address this issue for 1993. The DoH has commissioned a study of outcome indicators and is pressing for improvements in coding and audit of coding efficiency.

The DoH has bought all the world-wide rights to the Read Clinical Classification and has set up the 'NHS Centre for Coding and Classification' with Dr Read as a director. The Read system was of course developed for primary care and its application in other areas has yet to be established. The overall direction and development of the codes will be guided by a supervisory board including representatives of the medical profession.

An overall strategy for medical coding and classification for the next decade is planned and the report indicates that the DoH will be consulting with interested parties on the nature of that strategy.

The report concludes with a list of over 200 organisations who were involved in responding to the original documents; the Royal College of Psychiatrists is not among that list. This document sets forth the direction that information systems will take within the NHS review; the changes in the information systems will carry along changes in clinical practice, workload, and involve major areas directly relevant to psychiatry. This document is not for consultation and states that comments are not being sought on its contents.

There are, however, further areas of consultation being proposed and these involve such central concepts as diagnostic coding and outcome measures. It would be wise to be involved in these discussions if we wish to be part of the shaping of strategy rather than being shaped by it.

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Problem Drug Use: A Review of Training
Report by the Advisory Council on the Misuse of Drugs. London: HMSO. Pp 87. £5.50.

The latest report from the Advisory Council on the Misuse of Drugs (ACMD) surveys training needs for the full range of drug misuse services from prevention through to specialist treatment. The report regrets that training on problem drug use did not expand sufficiently in the 1980s to meet the growing, ever changing nature of the drug problem and the arrival of HIV infection. The shortfall applies to many disciplines but most patently to medicine. It is essential to build on the training initiatives that have been unfolded. The ACMD selects examples of the fresh measures that were introduced; to them should be added the WHO-inspired courses on medical and pharmacy education conducted by St George's Hospital.

The negative and pessimistic attitudes of many doctors towards treatment of drug misuse is understandable in view of their undergraduate and postgraduate lack of training. A major recommendation of the report is expansion of the number of departments of addiction behaviour in medical schools. The departments will act as catalysts for education, research and service provision. Almost as an emergency step it is proposed that each medical school should quickly establish a working group to implement training on drug misuse and on the associated topic of problem drinking.

The deficit is pinpointed in psychiatric training of insufficient senior registrar posts for substance misuse. Here it may be noted that the deficiency persists despite an increased provision of senior registrars granted in the late 1980s partly with an intention to close the gap. Only four new posts in substance misuse were created in England and Wales; Scotland received no increment. During 1990 there has been

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