What's happening to the statistics?

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The Office for National Statistics describes its current role in the following terms 'The Office for National Statistics (ONS) is a government department. Impartial information is vital to an open and democratic society. ONS is the principal provider of official statistics about the UK. Our information is used by government to make decisions about society and the economy, and by people to better understand their country.'[1]

This is the position before the passing of aim legislation aimed at making it more independent. Even with greater independence, ONS will have other constraints on its ability to produce and publish statistics. The resources available are decreasing, with staff reductions of 700 full time equivalent between March 2004 and March 2008.[1] The relocation of 850 jobs out of London is adding further to the loss of experienced staff with specialist knowledge. ONS has to fulfil statutory requirements and to collect data to inform government priorities, so the potential for new analyses is extremely limited. In the past, there has been a considerable amount of external collaboration but measures for disclosure control are now making it more difficult for outsiders to obtain and analyse data.

Access to data

Accessing published data is challenging, as it is not easy to find publications and data on ONS' web site. Many are less extensive than in the past. For example, the decennial supplement on occupational mortality, has traditionally consisted of detailed analyses by social class of mortality in the years around the census year. Analyses related to the 2001 census are being restricted to just three articles in ONS' journal, Health Statistics Quarterly.

Users who need analyses which are more detailed than those in publications may be able to elicit them by an asking an MP to table a parliamentary question. Alternatively, if their needs are more complex, they could pay for ad-hoc analyses. Publishing fewer analyses is likely to increase the demand for these but ONS now has fewer staff to provide such services

Arrangements for publication of data badged as ‘National statistics’ is set out in the National Statistics Code of Practice.[2] These standards do not necessarily apply to ‘other products’ or ‘management information’. Some of these data, for example the monthly NHS waiting time statistics, are readily accessible, while others, such as data from Local Delivery Plan Reporting, are not. In addition, increasing privatisation of NHS services, means that some data are ‘commercial in confidence’, even if they relate to services commissioned with public money.

Consulting the public – who sets the agenda?

ONS engages in a considerable number of public consultations about its work, but it is clear that the agenda is set from inside government. For example ONS web site showed this list of publications open at the time of the 2007 Radical Statistics conference:

> Equality for Disabled People: measuring progress Office for Disability Issues, Department for Work and Pensions
> Geography Policy Public Consultation
> Education consultation: measuring performance in our public services
> Measuring performance in our public service: Establishing the principles
> Business Register and Employment Survey for Businesses
> National Accounts consultations.

A number of factors affect the extent of user involvement in setting priorities for statistics. Some consultation exercises may be extensive as is the case with the census. Others initiated by ONS or government may have much more restricted questions. Subject-based user groups and Statistics Users Forum do their best to participate in these consultations but they are run by volunteers so their capacity is limited.

Statistics about health and social care in England

Over the past few years the organisations collecting and publishing statistics on this subject have proliferated. A limited amount of this is still undertaken by the Department of Health, but much of the work it undertook has been transferred to the Information Centre for Health and Social Care. Although the Healthcare Commission's primary role is regulation, it also collects some information and has an extensive role in recycling data collected by others through the NHS. The same applies to the National Patient Safety Agency, which also has oversight of the confidential enquiries.

The Information Centre for health and social care in England was set up in April 2005 as a special health authority. It is directly accountable to parliament. Although its primary aim is to rationalise and coordinate information collection, its initial statement of aims had an overwhelming emphasis on reducing burden of data collection. By February 2007, this had been recast in a more positive vein.

'The Information Centre for health and social care is working to make information more relevant and accessible to the public, regulators, health and social care professionals and policy makers, leading to improvements in knowledge and efficiency. The IC is a special NHS health authority that collects, analyses and distributes data to reduce the burden on frontline staff, releasing more time for direct care.'[3]

Since our conference, this has changed again, with a redesigned web site making data more accessible and a mission statement aspiring to provide 'an independent perspective on the quality, validity and application of information to support improvement in health and social care.'[4]

Even so, using the data can be challenging. For example, national headline data show real increases up to September 2005 in the numbers of nurses either directly employed by NHS hospital trusts or in general practices.[5] Up to 2002, when the Department of Health was responsible for inspecting private homes and hospitals, it collected data about the numbers of nurses employed in them, but collection of these data appears to have ceased once the Healthcare Commission took on the task of regulation. Even where data still exist, it is difficult to assess the extent to which local trends compare with national headline figures, because repeated reorganisations inevitably lead to boundary changes.

Privatisation of the analysis of NHS data

There has been a considerable increase in the extent to which data analyses paid for by public funds have been outsourced to private companies whose analyses are available only to those who pay. Dr Foster was launched as a consultancy in January 2001 with its 'Good hospital guide' in Sunday Times. It developed rapidly with contracts from other newspapers, the Department of Health and NHS. It produced a series of articles, 'Dr Foster's casenotes' in the British Medical Journal which were widely perceived as free advertising.

It then started approaching Department of Health to discuss a 'joint venture'. In February 2005, the joint venture Dr Foster Intelligence was launched by the Secretary of State after Information Centre paid £12million in cash for a 50 per cent share in the joint venture. This deal was criticised by competitors for the lack of competitive tendering. In February 2007, the lack of tendering and other aspects of the deal were criticised in report by National Audit Office.[6]

Data collection is still undertaken by the Information Centre and the data remain in the public domain. Basic tabulations are still freely available on the Information Centre web site but 'added value products' produced by private sector are purchased by NHS bodies with public funds.

The extent to which these data may or may not be publicly available and the way they are promoted was illustrated in October 2006 when news reports proclaimed the availability of data which would reduce NHS costs. The source was not cited but turned out to be a ministerial press release from the Department of Health on October 23 2006.[7]

> **‘Smarter working and improved productivity’**
> ‘Tackling wide variation could deliver benefits for patient care and better value for money. Improved NHS productivity and better efficiency could unlock resources worth £2.2bn for the NHS and improve patient care at the same time, Health Minister Andy Burnham said today.’[7]

The press release described a set of clinical indicators and a web site, along with the savings which, it claimed, could be made if the value of the indicators was reduced to their baseline value.

> **‘A breakdown of the productivity opportunity for the clinical indicators’**

a. Bed days saved by reducing variation in length stay	£975m
b. Reduced emergency admissions	£348m
c. Reduced variation in outpatient referrals	£278m
d. Management of surgical thresholds	£73m
e. Increased rates of day case procedures	£16m
f. Reduction in preoperative bed days	£510m
TOTAL	£2.2bn ‘

> **‘NHS Better Care, Better Value Indicators’**
> The text on the web site states that ‘The NHS must demonstrate that it is making the most effective use it can of public money to deliver quality healthcare. This website is designed to help local NHS organisations do this. It is based around 15 high-level indicators of efficiency that identify potential areas for improvement in efficiency. These indicators can be used locally to help inform planning, to inform views on the scale of potential efficiency savings in different aspects of care and to generate ideas on how to achieve these savings.’

A certain amount of information was given on the web site, which belonged to an organisation called the NHS Institute for Innovation and Improvement, based in the University of Warwick, but users requiring greater detail were referred to a facility which was not readily available on the web site.

> ‘As part of our range of initiatives to support this process, the NHS Institute has developed a cost-effective, highly usable, web-based tool that will help organisations to benchmark their performance, prioritise areas for improvement and track progress.
> The NHS Indicator Explorer offers one simple system for commissioners and providers to view and monitor their performance in the following four key areas:
> Clinical effectiveness, finance, prescribing and procurement, and workforce.
> The tool allows users to drill down to see their data at specialty-level as well as run peer group comparisons.’[8]

To access these data, users in individual acute trusts and PCTs had to pay ‘a nominal price of £2,500 per annum.’ to Dr Foster Intelligence.

There was also a description of the rationale for further privatisation.

> ‘The existing health and social care information services and business intelligence market is perceived to be under-developed, served through a combination of competing in-house services and specialist businesses.
>
> The government points to the lack of information and business intelligence as a key factor slowing the pace of service-improvement. Through a range of initiatives, government seeks to expand the information services market and enable NHS and social care organisations to improve the services and outcomes for patients, clients and their families.’[8]

An overview

Overall, there are a number of influences and constraints on the agenda for data collection, analysis and publication. The current target culture focuses on very specific items, such as operations and waiting times. There is a dearth of information about care outside hospital. It is difficult to monitor local trends because of organisational change. There is a lack of data about new forms of care, for example independent sector treatment centres.

The National Programme for IT is the source of future data but currently there are many problems with its implementation. Although the National Audit Office identified some of its problems, it does not assess data quality in its 'value for money' reports.

In their different ways, commercial confidentiality and disclosure control both limit the availability of data. Loss of experienced analytical staff through relocation of government statistical services and reorganisations of the NHS limits the public sector's capacity to do analyses which are adequate, let alone independent.

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