With nurse practitioners, who needs house officers?

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The boundaries between the work of doctors and that of nurses are changing, with nurses taking over important parts of junior hospital doctors' clinical work. In 1993 an exploratory study was carried out to identify the professional, educational, and management issues that such developments raise. Interviews were carried out with a range of stakeholders in three innovatory posts in which nurses were doing much of the clinical work of house officers. A complex picture of perceived benefits and problems for patients, junior doctors, and nurses emerged. These seemed to be associated with (*a*) the extent to which the contribution of professional nursing was valued in the new role and (*b*) the amount of clinical discretion which the postholder was allowed, this depending on the type of preparatory education provided and the management of the post. The study points to the need for strategic issues—such as the development of appropriate education and the professional recognition of these new clinical roles —to be addressed at a national and regional level.

The boundaries between the clinical work of doctors and that of nurses in the acute sector are being redrawn owing to a complex mixture of pressures coming from new technologies and treatments, changing patterns of health care delivery, and the processes by which services are purchased and provided. To doctors, perhaps the most obvious pressures are the requirements of the "new deal" to reduce juniors' hours,[1] and the Calman report's recommendations to shorten specialist training.[2] Both will reduce the availability of juniors for service work, making nurse substitution an option to be considered. In July 1992 the United Kingdom Central Council for Nursing, Midwifery and Health Visiting published new statutory regulations[3] intended to liberate professional nursing practice from previous rules that had limited the activities they could undertake outside basic nursing.[4]

By mid-1992 anecdotal accounts of nurses taking over important parts of junior hospital doctors' clinical work were beginning to appear in the health service press. At the time there was little systematic research in Britain to indicate the prevalence and types of such developments or their implications for the professions concerned and for patients. We therefore carried out a six month exploratory project in 1993 (*a*) to map the way clinical work traditionally done by senior and preregistration house officers was being taken on by nurses, physiotherapists, and other staff groups; (*b*) to identify boundaries for classifying these types of new post; and (*c*) to identify and gain understanding of the professional, educational, and management issues that the posts raise. Here we address the last two of these aims, with reference only to the changing boundaries in clinical work between doctors and nurses.

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Methods

Central to the research was a multiprofessional working group, which provided a powerful resource for identifying relevant information and interpreting results from different organisational perspectives. It included two chief executives (one purchaser, one provider), a senior nurse educator, a consultant surgeon, the junior doctor from the regional taskforce, a consultant occupational psychologist, a social scientist specialising in health care, the project's researcher, and the authors. Meetings were facilitated by one of the authors (SB), who had the least direct professional involvement in the issues being studied.

With so little known about the nature of the organisational changes being investigated, the structure of data collection and subsequent analyses were broad and relatively untied to predetermined theory. However, three key issues influenced the focus of the research.

- The design and management of new roles in ways likely to support good quality patient care
- Respect for professionals' requirements for appropriate education, management, personal support, and career structures when required to take on new roles and drop old ones
- Respect for the role of innovators—recognising the risks they take and the consequent need for confidentiality.

COLLECTION OF DATA

We collected descriptive information to map the types of professional skill mix changes referred to above. This was done by literature searches and by contacts through networks of junior doctors, chief executives, clinical tutors, the regional taskforces, and senior nurses. From this information we chose three case studies as examples in which notable shifts in professional boundaries seemed to be occurring, with nurses taking over large parts of the clinical roles of senior house officers or preregistration house officers. The terms "nurse practitioner" and "nurse specialist" and other related titles may be used differently by hospitals for posts requiring varying levels of skill, roles, and responsibilities. We have therefore used the term "postholder" to refer to the nurses in the three posts discussed.

Information for the three case studies was obtained from job descriptions and other documents about the posts and from semistructured single interviews (by SD) with different stakeholders in the development, including the nurses in the new posts and the junior doctors, nurses, consultants, and other key staff with whom the postholder worked. We explored their experience of the new post and perceptions of its benefits and problems.

The interviews were audiotaped and transcribed, and the key issues were identified. SB checked and clarified interpretations made by SD, referring to the audiotapes in a sample of interviews. Summaries of case material were then analysed by the multiprofessional group.

Finally, we gauged the validity and meaning of the study's findings at a national level by discussion at a closed seminar with a selected group of senior health service managers and professional leaders.

Description of case study material

The three case studies of new clinical posts (posts A, B, and C) were conducted in April and May 1993. The first nurses to hold posts A, B, and C had been in their post for nine, 18, and eight months respectively. Although posts A and B were developed independently

in separate trusts, they had many similar organisational and clinical features, and we have therefore considered them together.

POSTS A AND B

In posts A and B experienced nurses who had worked in the employing hospital for several years partially substituted for preregistration house surgeons in work on surgical firms with no such doctors (gastroenterology in post A, urology and general surgery in post B). The postholders had no nursing duties and were clinically accountable to consultants. Both posts had been developed rapidly over a few months, each in response to a new consultant appointment without an associated preregistration house officer. The initiatives were consultant led, with minimal nursing involvement (although the director of nursing advised on the job specification and overall management of post A).

At the time of interview, postholders were paid the equivalent of nursing grades G and H and worked between 40 and 60 hours a week. Their work included the medical clerking of routine admissions; limited clinical examination; and specified clinical interventions, such as insertion of intravenous cannulas, urinary catheters, taking arterial and venous blood samples, and giving intravenous additives. The postholders also monitored the day to day condition of the consultants' ward patients.

To prepare for the job, the postholder in post A shadowed a house surgeon for one week; in post B the postholder underwent a two month training programme with several hospital departments and senior staff, as well as shadowing a house surgeon. Both postholders had supervision and teaching "on the job."

Organisational features of development of posts A and B and of post C

Feature	Posts A and B	Post C
Organisational boundary of development	Within each trust only	Region wide
Problem addressed	Acute; management; no preregistration house officer for new consultant appointment	Long standing; professional concern of doctors and nurses; quality of patient care
Planning phase	Short (few months)	Prolonged (several years)
External funding of development	None	Regional health authority
Professional leadership	Consultant led (but director of nursing involved in post A)	Shared by consultants and senior nurses
Extent of nursing involvement in planning	A little	A lot
Essential previous professional training for applicants	Nursing	Nursing
Designed to advance the professional nursing careers of postholders?	No	Yes
Training for new work	Brief: one week shadowing preregistration house officer (post A); 2 months' teaching programme tailored to postholder's needs (post B)	Extensive: 9 month full time course*

*Validated by English National Board for Nursing, Midwifery and Health Visiting.

Features of clinical work and accountability in posts A and B and in post C

Posts A and B	Post C
Professional nursing work explicitly excluded	Advanced nursing role
Partial substitution for work of preregistration house officers, including much of their routine clinical work	Almost total substitution for clinical work of senior house officers
Medical work excluded: all emergency admissions, some physical examinations, diagnosing, initiating investigations and treatment, tasks legally confined to qualified medical practitioners (such as prescribing)	Medical work excluded: only tasks legally confined to qualified medical practitioners (such as prescribing)
Accountability to consultant for clinical work	Accountability to consultant for clinical work
Accountability to director of nursing (post A) or consultant (post B) for management issues	Accountability to director of nursing for management issues

POST C

Post C was part of a region wide development of a new clinical role for neonatal nurses, combining advanced nursing with the complete substitution, when required, for the clinical work of neonatal senior house officers (except for tasks legally limited to medical practitioners). These nurses, referred to as neonatal nurse practitioners, were clinically accountable to the consultant. An integral part of the initiative was the development of an advanced neonatal nurse practitioners' course validated by the English National Board for Nursing, Midwifery and Health Visiting. The initiative was supported financially by the regional health authority and had a lead time of several years for detailed planning and development. It arose from the shared desire among the region's neonatalogists, paediatricians, and neonatal nurses to improve the quality of patient care. The development was planned jointly by doctors and nurses and included a visit by a multidisciplinary team to the United States to learn from the experience there. Basic nursing standards were established in units as a first step to defining the advanced nursing role.

In the unit that we visited, the postholders worked for most of the time interchangeably with senior house officers, taking part in the house officers' rota. They took over the whole rota when new senior house officers were appointed. Posts were grade H and required a 37½ hour week. Only nurses qualifying from the advanced neonatal nurse practitioner course were eligible for appointment. This course was aimed at experienced neonatal nurses with more than basic training in the specialty. A preliminary 10 week basic science programme was followed by a nine month full time course comprising six months' formal teaching and three months' clinical apprenticeship in the nurses' home units. The nurses were supported by personal mentors in the nursing and medical professions, including qualified postholders.

Analysis and interpretation of case study material

ORGANISATIONAL AND CLINICAL FEATURES OF POSTS A, B, AND C

The table and the box summarise the main organisational and clinical features of the three posts. These suggest two different types of development. Posts A and B were developed quickly by doctors and excluded nursing duties. Limited training allowed little clinical discretion in diagnosis or treatment. The postholders worked within the medical arena of control, organisation, and accountability. This type of job was described by one preregistration house officer as producing a "watered down doctor."

In contrast, the development of post C was lengthy and built on the contributions of both the nursing and medical professions. Its important educational input was designed to give experienced nurses the same type of clinical discretion as senior house officers in investigating, diagnosing, and managing acutely ill neonates. The postholders were described by interviewees as "more than a doctor, more than a nurse."

SIMILARITIES IN PERCEPTIONS OF BENEFITS AND COSTS BETWEEN THE THREE POSTS

The postholders all reported that they enjoyed their jobs and had gained new skills and personal satisfaction from being trailblazers. Against this, however, a common concern emerged about the stress of moving from their previous nursing role to something new and largely unknown. Postholders spoke of the uncertain-

Main differences in perceived benefits and costs between posts A and B and post C

Posts A and B	Post C
For doctors	
No reduction in hours for preregistration house officers, though workload reduced	Reduction of hours as well as workload for senior house officers
	Training time available for senior house officers
Considerable increase in workload of senior house officers and middle grades	Small increase in workload of middle grades
	Large increase in consultant teaching (to postholders)
	Threat of reduced training opportunities for senior house officers
For nurses	
No career path for nurses	New career path in clinical advanced nursing
No associated nursing qualification	Associated transferable, validated, advanced nursing qualification
Possible deskilling of experienced professional nurses	
Postholders professionally isolated and professionally vulnerable if problems arose from practice	Postholders professionally and educationally supported
For management	
Quick solution to immediate problems	No quick solutions
Low educational and management costs in setting up	High educational and management costs in setting up
Fragmentation of delivery of bedside care	Potential for improved quality of front line clinical care (postholder's training, continuity, knowledge of organisation)

ties surrounding their professional identities and how these could result in a feeling of isolation and "not belonging."

In all three sites the postholders, nurses, doctors, and managers identified gains from having front line clinical staff experienced in their hospital's organisation and ways of getting things done. They also suggested that the continuity of the postholders' appointments, which were for at least a year, was beneficial compared with the disruptive effects of frequently changing junior medical staff. They pointed out, however, that the salary costs of the postholders were greater for fewer hours worked that those of preregistration house officers (for posts A and B) and of senior house officers (for post C).

DIFFERENCES IN PERCEPTIONS OF BENEFITS AND COSTS BETWEEN POSTS A AND B AND POST C

The box shows the differences in perceptions of benefits and costs between posts A and B combined and post C.

For doctors

For posts A and B doctors of all grades reported that the posts probably reduced the workload of preregistration house officers but had minimal impact on their hours of work. Senior house officers and middle grade doctors, however, reported an increase in workload, apparently due to the limited training for new postholders and their resulting need for advice, teaching, and supervision. These senior house officers and middle grade doctors also had to take on work excluded from the new posts but normally done by preregistration house officers. In one site this excluded work was sufficient to cause the senior house officers to complain to the clinical director and the postgraduate dean.

For post C the doctors reported a reduction in senior house officers' hours when postholders were substituting for them and taking part in their rota. When new senior house officers started, the postholders took over the new doctors' service work, so freeing up a two week training period for them. The amount of work displaced to senior house officers and middle grade doctors was much less than for posts A and B. The doctors interviewed suggested that the advice and supervision needed by the postholders were similar to those given to most senior house officers.

In all three sites a few interviewees were concerned that the new posts might reduce training opportunities for junior doctors, although in practice this did not seem a problem.

For nurses

Although the nurses in posts A and B enjoyed the new work, few other benefits for these nurses were identified. Both postholders identified the absence of a recognised career path and a transferable, recognised professional nursing qualification as features requiring urgent remedy. Ward sisters were concerned that these very experienced nurses would become deskilled in these posts owing to the underuse of their nursing skills. They recognised that the postholders carried much responsibility for developing the posts and, being professionally isolated, could be vulnerable if problems arose from their clinical practice. They were also concerned that the absence of an easily accessible doctor for sick patients on their wards could increase the workload and stress of ward nurses.

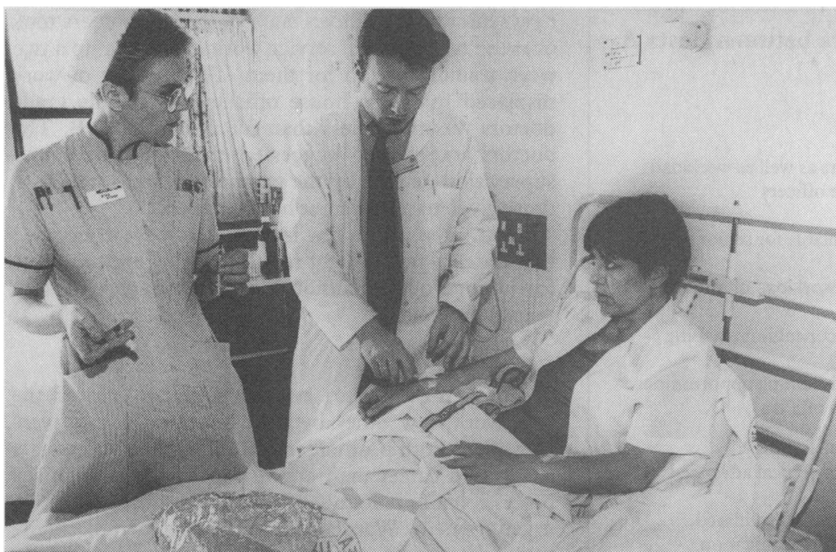
Nurses were excited, however, that for post C a new career path was being created that could keep experienced nurses in clinical work with a recognised and transferable advanced qualification. They suggested that another benefit for nursing was the creation of additional trained clinical teachers who provided a model of how nursing can increase its clinical authority and professional autonomy. The professional and educational support for the postholders was such that the nurses did not identify any particular professional vulnerability, as they did for posts A and B. The main problems identified by the neonatal nurses were the personal risks of starting out on an extensive new training and role with uncertain employment opportunities when they had families and mortgages to support.

For management

Turning to broader organisational issues, differences in the perceived impact of the developments on patient care were reported, this being most favourable in C; also in the timing when benefits and costs occurred.

Discussion

The cases described have all evolved considerably since this study. They are now part of a growing number of innovations[5] likely to increase further as the pressures to reduce junior doctors' hours continue and shortages of doctors in some specialties become more apparent. Alongside the more radical experiments in the redivision of medical and nursing clinical work, there is gradual change as doctors and nurses adjust to new working situations.[6,7] Since this study we have heard of other posts similar to posts A and B and developed mainly by doctors. In addition, new occupational groups, such as surgeons' assistants, are emerging,[8] with recruitment largely (but not exclusively) from nursing, with the training and work defined and supervised by surgeons. New posts developing the careers of experienced nurses within nursing, such as in post C, are likely to increase. The recent specification by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting of standards of education and practice for the qualifi-



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Nurses could increasingly take on some clinical roles traditionally held by doctors

cation of "specialist practitioner"[9] (to be recorded on the professional register) will offer opportunities for new course developments in addition to existing validated postregistration nursing courses relevant to the acute sector—for example, in the specialties of accident and emergency; ear, nose, and throat surgery; gynaecology; and neonatology.

REQUIREMENTS FOR PRELIMINARY STAGES OF EVALUATION

Just as new surgical techniques require careful evaluation and control,[10] so too do these innovations in the divisions of labour delivering front line clinical care.[11] The problems of studying such heterogeneous working practices are considerable[12] and are beginning to be confronted at the boundaries between nursing and medical work.[5 13] Until there is identification and understanding of the essential and generalisable features of these new working practices (as opposed to features specific to the organisation studied), controlled trials will be of limited value.[14 15]

This type of small, exploratory study is not intended to provide conclusions. However, it illustrates how in a new field of study a rigorous qualitative approach,[16 17] combined with a collaborative process of working[18] drawing on a range of service and professional experience, can quickly identify and frame important research and management issues requiring further investigation. Some of these issues are currently being investigated by members of the working group.

IMPLICATIONS OF MAXIMISING OR MINIMISING SCOPE OF NEW CLINICAL ROLES

Our research suggests that the substitution of nurses to undertake large parts of house officers' clinical work is neither a cheap nor easy solution to the longstanding problem of junior doctors' hours. The data from the three case studies imply that when the scope of these new clinical roles is maximised as an expansion of nursing, and considerable clinical discretion allowed (as in post C), long term benefits for trusts may result, such as improved quality of patient care, the potential for reduced juniors' hours with almost all the work of senior house officers being done by nurses in the new roles, and the development of a new cadre of clinical teachers for doctors as well as for nurses. The short term costs, however, may be considerable for trusts if, independently of each other, they take on the detailed design of such posts with in house provision of carefully tailored education and training. There are fears too that if nurses take on increasing amounts of technical and medical work then characteristics highly valued in the profession may be threatened—for example, skills in caring and communicating and in providing a holistic approach to patients' treatment, and encouraging patients' active participation in it.[19 20]

When the scope of the clinical role is relatively minimal, as in posts A and B, with no nursing duties and little training and clinical autonomy, the evidence suggests that trusts may find short term benefits to immediate medical staffing problems. The overall impact on junior doctors' hours, however, will be slight, while the workload of junior doctors working alongside such posts may increase. The long term impact of such posts on the professions concerned and on patients—for example, the potential fragmentation of care—needs further study.

NEED FOR NATIONAL AND REGIONAL STRATEGIC PLANNING

If these and other types of new clinical roles are to be developed widely to benefit all the main stakeholders then certain strategic issues—particularly role specification and appropriate education and professional recognition—need addressing both nationally and regionally. As divisions of labour change, issues of professional power and control are likely to become increasingly important, centred on two interrelated themes: (*a*) the type of professionalism that will operate—old style, defensive and restrictive practices maintaining closed and carefully boundaried groups[21] or a new type of professionalism reflecting the realities of changing clinical practices in many areas of nursing and medicine so long as they primarily benefit patients[22 23]; and (*b*) the extent of understanding and appreciation by both professional groups of medical and nursing work, the nature of the differences, and how they interrelate.[23 24] Our project suggests that nursing work may be undervalued because of a lack of knowledge among doctors about the scope and nature of nursing and because of the recognised difficulties of describing the caring aspects of nursing work in ways that will not be dismissed as trivial.[23]

CONCLUSION

We have described some radical changes in ideas about who does what at the front line of clinical care. Such ideas are valuable and may have a greater potential for achieving efficient production in health services than new techniques and equipment.[25] Mechanisms are needed, however, to share and link local learning with the development of national and regional policies, with cooperation between the main professional and educational bodies as well as senior NHS managers. The new framework for planning and commissioning education and training in the NHS[26] may provide such a mechanism. It will be important, however, for the NHS Executive, regional education and development groups, and local health consortiums to ensure that the development of education to support these types of clinical innovation is not swamped by the main activity of purchasing more traditional education for the rest of the NHS workforce. In addition, the NHS Executive and regions should ensure that support for the training of newly created specialist staff groups requiring relatively small numbers in any one region is not overlooked.

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Hospital; Ann Lloyd, chief executive, Frenchay Health Care Trust; Sharon Lloyd, lecturer in organisational psychology, University of Bristol; and Margaret Williams, vice principal for preregistration nursing studies, Avon and Gloucestershire College of Health.

1 NHS Management Executive. *Junior doctors. The new deal.* London: NHS Management Executive, 1991.
2 Working Group on Specialist Medical Training. (K Calman, chairman.) *Hospital doctors: training for the future.* London: Department of Health, 1993.
3 United Kingdom Central Council for Nursing, Midwifery and Health Visiting. *The scope of professional practice.* London: UKCC, 1992.
4 Department of Health and Social Security. *The extending role of the clinical nurse. Legal implications and training requirements.* London: DHSS, 1977. (HC(77)22.)
5 Read S, Graves K. *Reduction of junior doctors' hours in Trent region: the nursing contribution. Report to Trent Taskforce.* Sheffield: Sheffield Centre for Health and Related Research, 1994.
6 Greenhalgh and Company Ltd. *The interface between junior doctors and nurses.* Macclesfield: Greenhalgh, 1994.
7 Harris A, Redshaw M. The changing role of the nurse in neonatal care: a study of current practice in England. *J Adv Nurs* 1994;20:874-80.
8 Holmes S. Development of the cardiac surgeon assistant. *British Journal of Nursing* 1994;3:204-10.
9 United Kingdom Central Council for Nursing, Midwifery and Health Visiting. *The council's standards for education and practice following registration. Programmes of education leading to qualification of specialist practitioner.* London: UKCC, 1994. (Registrar's letter 20/1994 and Annexe 1.)
10 Surgical innovation under scrutiny [editorial]. *Lancet* 1993;342:187-8.
11 Haines A, Iliffe S. Innovations in services and the appliance of science. *BMJ* 1995;310:815-6.
12 Wilson-Barnett J, Beech S. Evaluating the clinical nurse specialist. A review. *Int J Nurs Stud* 1994;31:561-71.
13 Touche Ross Management Consultants, South Thames Regional Health Authority. *Evaluation of nurse practitioner pilot projects. Summary report.* London: Touche Ross, 1994.
14 Pope C, Mays N. Opening the black box: an encounter in the corridors of health services research. *BMJ* 1993;306:315-8.
15 Sowden A, Sheldon T, Alberti G. Shared care in diabetes. Better evaluation is needed. *BMJ* 1995;310:142-3.
16 Yin RK. *Case study research. Design and methods.* 2nd ed. London: Sage, 1994.
17 Cassell C, Symon G, eds. *Qualitative methods in organisational research. A practical guide.* London: Sage, 1994.
18 Reason P, ed. *Human inquiry in action.* London: Sage, 1988.
19 Pearson A, ed. *Primary nursing: nursing in the Burford and Oxford nursing development units.* London: Chapman and Hall, 1988.
20 Salvage J. The new nursing: empowering patients or empowering nurses? In: Robinson J, Gray A, Elkan R, eds. *Policy issues in nursing.* Buckingham: Open University Press, 1992.
21 Stacey M. *Regulating British medicine: the General Medical Council.* Chichester: John Wiley, 1992.
22 Walmsley J, Reynolds J, Shakespeare P, Woolfe R, eds. *Health, welfare and practice: reflecting on roles and relationships.* London: Sage, 1993.
23 Davies C. *Gender and the professional predicament in nursing.* Buckingham: Open University Press, 1995.
24 Walby, S, Greenwell J. *Medicine and nursing. Professions in a changing health service.* London: Sage, 1994.
25 Normand CE. Changing patterns of care—the challenges for health care professions and professionals. In: Malek P, Vacani J, Rasquinha J, Davey P, eds. *Managerial issues in the reformed NHS.* Chichester: John Wiley, 1993.
26 NHS Management Executive. *Education and training in the new NHS.* Leeds: NHS Executive, 1995. (EL(95)27.)

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Use of Read codes in development of a standard data set

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General practice has a wealth of data that could be used for purposes such as assessing health needs, planning, and audit. If this potential is to be realised appropriate data must be easily accessible and of high quality. This article describes the experience of an information project team in developing and coding a standard data set, with the aim of meeting the needs of commissioners, public health, and general practitioners. The Read coding classification seemed the logical choice for the standard data set because Read codes are the basis of a standard classification of general practice data. However, the coding structure has several weaknesses that were difficult to resolve, and the standard data set had to be changed to match available codes. This paper may prove helpful to similar project teams attempting to develop and use a standard data set.

General practice is potentially a rich source of computerised information as over 80% of practices have computers[1] and 99% of the population are registered with a general practitioner. Although systems have been developed to assist clinical management, analysis of practice held information could highlight areas of clinical need. Resources could then be directed to these areas to restore the principle of equity in the NHS, which has recently been eroded.[2]

As a way of maximising the potential of computers in general practice, the Joint Computing Group of the Royal College of General Practitioners and the General Medical Services Committee recommended the Read codes for the standard classification of general practice data.[3] Although it did not fulfil all the criteria set by the group, the Read clinical coding classification (now known as Read 1) was most suitable as it allows access to a thesaurus of medical terms expressed in language suitable for general practitioners that is based on a hierarchical structure.[4] The intention with Read coding was to produce comprehensive information about individual patients to allow clinical decisions to be better informed and, by ensuring compatibility, to allow comparison of data for assessment and audit of health needs.[3] Accurate and comprehensive data would also provide the sampling framework for clinical and organisational research and development of services.

The Department of Health subsequently purchased the Read clinical coding classifiction,[5] and the National Coding Centre at Loughborough was established to maintain and develop the Read codes. Modifications have resulted in the widely available version 2 and the recently released version 3 of the Read codes. The Read classification, therefore, has almost universally been welcomed as the panacea of needs for computerised clinical information.

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The setting

The Wakefield and Pontefract primary care health information project was formed in April 1992 with growing awareness of the importance and use of information in primary care. It consists of a network of 10 general practices and representatives from public health medicine, the family health services authority, and researchers from the University of Leeds. The aims of the project are to improve the collection and transfer of high quality data from primary care by developing and coding a standard data set and to test its use for assessing health needs and planning management.

Developing a standard data set

The purpose of the standard data set was to encourage a consistent and uniform approach to the collection of potentially useful data by the practices. In order to engender a feeling of joint ownership and motivation to pursue the goals of the project, the data set was developed collaboratively by a working party of representatives from general practice, public health, and the University of Leeds. The items in the data set were defined by reference to practice demography, morbidity, and lifestyles which the working group agreed were of value to the practices and useful for wider planning of health care. Consideration was also