

1449

# Cabinet Office

## Management and Personnel Office

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	File Title  Office of Population Censuses and Surveys Review: National Health Service Central Register		File Number  <b>MGD 10/29/06</b>	Part/ Annex	
File Number  <b>MGD 10/29/06</b>	Disposal Directions		Signature	Date	
	Destroy after          years				
	Preserve		GP Lyché	12/1/88	
	Consider at <sup>1st</sup> / <sub>2nd</sub> Review				
Index Headings					
Functions			Privatisation		

Refer to	Date	Refer to	Date	Refer to	Date
MGCS	4.7.86				
<div data-bbox="333 1385 617 1550" data-label="Text" style="border: 1px solid black; padding: 5px; display: inline-block;">           ARCHIVES 1986         </div>  <div data-bbox="460 1550 1479 1907" data-label="Text" style="font-size: 2em; font-family: cursive;">           BA 17 / 1449         </div>   <div data-bbox="1195 2099 1793 2263" data-label="Text" style="font-size: 2em; opacity: 0.5;">           CLOSURE         </div>  <div data-bbox="1127 2318 1675 2551" data-label="Image"> </div>					

Mr Light

~~Pl Light~~ Pl open a new file  
in the OPCS registers

↳ OPCS Renewal  
National Health Service Central  
Registers. This is the first paper used  
25/6

Mr Hewes

Mr Dyche

Mr Morland

① Titchfield visit arranged for Thursday  
3 July (details to follow)

② Meeting with RCJ provisionally booked  
for Monday 7 July . 3.30pm

Dyche

20.6.86

Mr Hewes

cc Mr Dyche

Mr Marland

## VISIT TO SOUTHPORT

Depart 23 June pm. Bed & breakfast booked at Club House Hotel, 15 Leicester Street, Southport (Telephone S'port 33745). I have cancelled dinner on Monday night because of our probable late departure from London.

Tuesday 24 June

9.30 approx to see Mr Pennington (Grade 5)  
 12.30 " Lunch  
 1.30 - 3.30 Tow of NHSCR (with Eric Barton Grade 7)

Depart for London by 4pm (suggested time in view of probable delays on M1/M6)

Brace  
 20.6.86

## NATIONAL HEALTH SERVICE CENTRAL REGISTER

### 1. HISTORICAL

In September 1939, shortly after the outbreak of the second World War, the population resident in England and Wales was enumerated for National Registration purposes. This enumeration was used to provide identity documents and documents for food rationing and to control the call-up to the Forces. Every person enumerated was given an identity number against which particulars of that person were entered in transcript books at the offices of the Central National Registration Office in Southport. This initial enumeration formed the primary register of the population which has been maintained by the staff in Southport ever since. An additional register was formed of the children born after September 1939 and further registers catered for immigrants to the country and those discharged from HM Forces.

From the start of the National Health Service in 1948, National Registration identity numbers have been used as NHS Numbers as a means of ensuring that each patient has a unique identifying number, and from early 1950 extensive use was made of the National Register by the NHS to help contain the widespread inflation in the numbers of patients registered with Executive Councils throughout the country; after a short period of dual purpose operation, with the discontinuance of National Registration in February 1952, the office became the National Health Service Central Register. Its main purpose was, and still is, to arrange for additions and deletions from the lists of patients on which a per capita payment is made to NHS general practitioners and to ensure that when a patient moves to another area his/her medical history is transferred to the new doctor. It has been clear from the early days of the NHS that because of the movement of the population around the country, and the variations in personal particulars as quoted by patients, it would not be possible for local records to be accurately maintained without a central control and co-ordinating point.

The office is operated by Office of Population Censuses and Surveys on behalf of DHSS on an agency basis.

### 2. FUNCTION

Since 1951, as part of an integrated patient registration system, firstly with Executive Councils and then, from 1974, with Family Practitioner Committees, the NHS Central Register has maintained a central record of NHS patients with information for each patient consisting of NHS Number, name, date of birth, and ciphers identifying those FPCs, past and present, by whom the registration of the patient has been held, or the reason for the patient's exit from the NHS. NHSCR controls the issue of NHS numbers to new patients (births and immigrants) and disseminates information about the various circumstances (death, removal within or departure from the UK, enlistment into the Armed Forces, admission into long-term psychiatric care or imprisonment) which should result in the removal of a patient's name from a doctor's list and in the transfer or disposal of a medical record.

The filing and information recording system in use at Southport is wholly manual; the details of each individual patient appear against a ledger entry, sequenced in NHS Number order and there is a supporting card alphabetical index to enable searches to be made in respect of patient documentation which either lacks an NHS Number or bears an incorrect one.

The flow of information to and from FPCs concerning inter-FPC movements, changes of name, cancellations and resolution of identity queries is augmented by information from central government sources in respect of births, deaths, embarkations, enlistments, etc, for which NHSCR identifies the patient and ensures that the notification reaches the appropriate FPC.

About 6 million documents are processed at Southport each year to maintain the accuracy of Central Register and FPC records of which perhaps 25-30% bear no NHS Number and need to be searched for in order to establish the identification of the patient and the FPC holding the current registration.

[Currently (1985) 30% at least.]

Until recently NHSCR operated the national recall scheme for cervical cytology tests for which an annual average of 3.5-4 million forms were processed; the responsibility for recall is now being transferred to District Health Authorities and NHSCR is in the process of distributing some 9 million forms to FPCs in England and Wales for use in initiating their local schemes. The distribution will be completed by April 1984 but NHSCR will be heavily committed for the foreseeable future in tracing women due for re-testing who have either changed their name, or moved to a different FPC area since their last test.

[Distribution completed. Queries are 130,000 pa.]

At the request of FPCs, NHSCR records are used to make periodic checks of patient indexes held by FPCs. A check of an entire index in this way can be an important aid in identifying the inflationary elements in FPC records. For example, in a recent check NHSCR was able to identify and categorise approx 15% of the inflation in a Committee's patient registration system.

[This service is suspended due to staff cuts in 1985. However as FPCs computerise every effort is made to resolve queries and this becomes a pseudo Index Check.]

Families of members of the Armed Forces in the UK who are being treated by Service doctors, and all such dependents based outside the UK, are taken off the lists of NHS doctors and NHSCR is responsible for the routing of their medical records between their civilian doctors and the Service Medical Units. The medical records may be held at NHSCR while the family is in transit between Units or until an acceptance with a civilian doctor is notified following a period of Service medical care. This service is funded jointly by DHSS and Ministry of Defence.

All patients in England and Wales diagnosed as suffering from Cancer are registered by cancer registries and the national cancer registration scheme provides for these regional cancer registries to submit notifications of registered cancer patients to OPCS. Since 1971 cancer registrations have been recorded in the NHSCR and as deaths of all persons are routinely recorded in the Register, a special note is made when the death of a cancer patient occurs. In addition to notifying such deaths to the appropriate regional cancer registries, routine mortality follow-up information is passed to OPCS to permit the production of statistical analyses of cancer survival. Cancer registration is a powerful epidemiological research tool and provides data for the general monitoring of the public health as well as for retrospective and prospective studies of groups of people thought to be exposed to risks of cancer. To date the fact of cancer registration has been recorded at over 1.7 million entries in NHSCR and a further 200,000 notifications are received each year.

The NHSCR linked as it is to the 1939-1952 National Registration data and to current birth, morbidity and mortality notifications and population movement, makes a unique contribution to medical research.

In a typical prospective study a group of persons suspected to be at special risk of some disease is isolated, perhaps with a matched control group at normal risk, and all cases are followed-up to determine whether the disease becomes manifest or plays its part in causing their death. Sometimes the identification of the group at risk is made retrospectively and the study reveals their subsequent health, or more usually, the cause of their death, such details being obtained from OPCS.

NHSCR can be involved throughout the study, each person being identified at the onset in the Register and subsequent death or cancer registration or embarkation picked up in the routine recording of these events. In this way NHSCR plays a major role in the study, sometimes the whole study is based on it.

The use of NHSCR in following-up patients who are known to suffer from a particular disease, or who have had a particular form of treatment (operation, course of drugs, etc) is also quite common. Where the intention is to establish contact with the patient or, more usually, the patient's medical adviser, NHSCR provides the sponsor with the address of the FPC Administrator who is holding the current registration and it becomes his decision and responsibility whether to help further and in what form the help is to be provided.

Since 1960 NHSCR has been used in about 500 medical research projects. There are about 200 projects currently on hand, many of which will be dependent on NHSCR for many years ahead. Typically the sponsors of projects are OPCS, DHSS, other central government agencies and many individual research bodies based upon universities, hospitals, clinics and charitably funded research organisations. Where appropriate the cost of NHSCR resources is charged to the research sponsor and a prior assessment of the scientific, medical or social value of a proposed study and advice on the methodology to be employed is obtained from the Chief Medical Statistician at OPCS via whom all new projects are routed.

The Longitudinal Study provides a system in which for a 1% sample of the entire population of England and Wales, data held by OPCS about separate events occurring to an individual may be linked by use of the NHSCR. The information to be linked is drawn from the following sources - birth registration, death registration, overseas migration, causes of cancer and the decennial census of population. Over .5 million entries in NHSCR record the inclusion of the person in the study and all documentation and analysis of data is processed by OPCS under a high confidentiality classification akin to processing of Census data.

NHSCR provides the data on internal migration which are used in preparing the local population estimates which are required by DHSS and DOE for the Resource Allocation Working Party and the Rate Support Grants calculations. The data are obtained from a scrutiny of all inter-FPC and England-Scotland movements being recorded at NHSCR.

### 3. COMPUTERISATION OF NHSCR

The maintenance of the Register and the provision of the services to FPCs and others is a wholly manual operation. The records are mainly in the form of book registers and index cards and some have been in constant use since 1939; many of the characteristics of the operation would seem to be eminently suited to automatic processing - extremely labour intensive, with a large quantity of basic data, frequent updating and large number of different varieties of outputs.

The possibilities of using computers to assist in the operations of the Register have been considered on several occasions, most recently in 1978-79 when a Feasibility Study into the possible use of computers was mounted jointly by NHSCR and the Computer Division of OPCS. Control of the Study was undertaken by a Steering Committee which included a representative of DHSS at Asst Secretary level.

[Latest study is the A Andersen report which is in the process of implementation in FPCs and NHSCR. A full update on this project should be acquired.]

The recommendations of that Study were that a NHSCR based on an interactive computer system thus retaining the expertise of the NHSCR staff, would be more effective, much more efficient in terms of manpower resources and in addition to producing improvements in current activities, would provide a sound basis for extensions to those activities. The cost would be of the order of £10 million, mainly attributed to data capture costs, spread over a number of years; the project would take several years to bring on line and many further years before it could be seen to break even financially.

The financial climate at the time the Report was completed and the uncertainty the Civil Service cuts programme would have on the workload of NHSCR led to action on the Report being delayed.

Computerisation of FPCs notwithstanding there appears still to be a need for a national register of patient registrations for the foreseeable future and in recent months NHSCR and OPCS have been giving some thought to the planning of an approach towards a computer-assisted NHSCR, less comprehensive than that described in the 1979 Report and much cheaper to implement. Initial planning will soon be in hand for the design of a pilot scheme to be introduced during 1984/85.

April 1983

NHSCR - Medical Research and Cancer Registration

Use of the NHSCR as a means of rapidly identifying and reporting deaths in study populations began in 1961 with a study of a group of workers who had been exposed to radioactivity in the course of applying luminous material to instrument dials. Over the next 25 years a further 270 studies were added to the list (50 in the last 2 years). The system depends on the fact that the NHSCR provides an index of virtually all persons in England and Wales which is routinely supplied with copies of the draft death entry (form 310) so that persons known to be dead can be withdrawn from the lists of general medical practitioners held by Family Practitioner Committees (FPCs) and further capitation fees in respect of the deceased can be stopped. By suitably marking (flagging) the record in the NHSCR in respect of each person in a study group, details of the death can be sent to the research worker as soon as the record is associated with death in the course of the routine system.

A further 100 projects are in preliminary stages. The NHSCR can also be used to assist medical research in other ways. Research workers (including clinicians) sometimes wish to maintain or renew contact with living members of study populations. For this purpose NHSCR is able to supply the research worker with the identity of the FPC in which the person was last reported as having been registered with a general practitioner. The research worker is then directed to make further enquiries through the administrator of the FPC who may put him in touch with the general practitioner concerned, through whom any approach must be made. This single check in the NHSCR files can also be used to make a once-and-for-all check for deaths in a study group. This facility has been used in respect of 150 studies since 1974.

Yet another facility, the potential of which has been realised only recently, is to use the 1939 National Registration element of the NHSCR as a means of identifying a study group for subsequent follow-up. This stems from the availability in the 1939 National Register of information on occupation within households in geographic clusters. The arrangement makes it possible to follow up local population groups or, coupled with knowledge of the location of a particular industry or process, facilitates the identification of occupational study groups. The household grouping has led to studies of the familial aggregation of causes of death, and has assisted in the formation of a register of twins.

The potential value of the NHSCR for medical research was further enhanced in 1970 by the acceptance of the recommendation of the Advisory Committee on Cancer Registration that mortality follow-up of cancer registrations for the production of survival statistics should be operated through NHSCR rather than by the cumbersome and patchy mechanism of the regional bureaux. As was appreciated at the time, the routine flagging of all cancer registrations in NHSCR would enable registration to provide an alternative end-point for studies of cancer epidemiology. The latest report of the Advisory Committee on Cancer Registration draws attention to the increasing importance of registration rather than death from cancer as an end-point in view of improvements in the survival from cancer. Over 2.5 million registrations of cancer since 1970 have been flagged at NHSCR.



The wide range of studies and their importance point to the value for medical research of the facilities at NHSCR. Among the earliest projects to use these facilities were studies of the hazard of radioactive material and of asbestos and of the determinants of coronary heart disease. More recently NHSCR has assisted in the follow up of women using the oral contraceptive pill and in the evaluation of the hazards of cadmium both at Shipham and in industry. Recent projects include studies of the toxicity of pentachlorophenols (245T used in agriculture), of formaldehyde (urea foam in cavity wall insulation), cancer and mortality in West Cumbria, participants in UK Nuclear Weapon Test and Early detection of Breast Cancer. Many of the studies are sponsored either by the Medical Research Council or the Employment Medical Advisory Service of the Health and Safety Executive. Other sponsors include DHSS, the Home Office, the United Kingdom Atomic Energy Authority, the National Radiological Protection Board, major individual companies (Fisons Ltd, Shell Oil Co., ICI Ltd) and industrial groups (Chemical Industries Association, British Rubber Manufacturers Association), the Royal College of General Practitioners, the World Health Organisation, the Irish Medico-Social Research Board and charitable agencies (Imperial Cancer Research Fund, National Birthday Trust Fund). The nature of the support for many of these studies is such as to suggest that they have been carefully vetted for their importance and scientific merit before being submitted.

It is worth considering the advantages of the facilities at the NHSCR over those of any alternative arrangement such as a death index. Quite apart from the work that would be necessary to set up a death index, with which would be coupled the question of how retrospective it should be, it could never match the ability of the NHSCR to check on loss, to follow-up through migration, and it is questionable whether it could efficiently offer the speed of the present service.

MANAGEMENT IN CONFIDENCE

OPCS REVIEW: NOTE OF MEETING WITH MR. PENNINGTON, NHSCR  
SOUTHPORT 24 JUNE 1986.

Present	Mr. M Penninton	OPCS
	Mr. R Hewes	Review Team
	Mr. M Marland	..
	Ms. D Pace	..

Mr. Hewes opened the meeting by briefly describing the background to the review, and the work that the study team had done so far. Mr. Pennington continued by describing the work and "raison d'etre" for the NHSCR.

The NHSCR is a patient data base, and is used for a variety of purposes. It consists of three registers: a primary register and its alphabetically name sorted complement called AI1, a secondary register and its alphabetically name sorted complement AI2, and a current register enumerated by NHS number.

The primary register - held in a series of bound volumes of hand written books, comprises an ordered list of all citizens alive in England and Wales in 1939 by identity number and postal address. AI(1) is its alphabetically sorted equivalent. These two registers are updated by deaths and medical histories only. The secondary register runs from 1939 to 1965 and comprises all people born since 1939, and immigrants registering with an FPC by address and identity number. AI(2) is its alphabetically sorted equivalent but is missing a section of the population who were 16 years and under when it was compiled in 1952 as a result of an unfortunate administrative decision. The best estimate is that it is 50% complete from 1939 to 1952; 90% complete from 1952 to 1962 and 100% complete from 1963 to 1965. The current register comprises all births from 1965 onwards by NHS number and immigrants registering with an FPC. All three registers are updated by changes of name whenever the information is available - usually from FPC's. Medical histories of treatment obtained under the NHS are included on all three registers, and this provides the basis for all the epidemiological research.

The main customers of the NHSCR are the 98 Family Practitioner Committees who use it for two main purposes. These are:

for the identification of patients NHS numbers, and the transfer of medical records whenever a patient changes doctors;

to enable the FPC to pay the correct capitation rate to each general practitioner

In respect of these two principal uses, he made the point that if the 98 FPC's could theoretically deal efficiently between themselves, there would be no need for the NHSCR.

Mr. Pennington summarised some of the other uses of the Register, and of the organisation generally - some of the following information on the uses of the NHSCR were also gleaned from a

port tour of the establishment led by Mr. Eric Hammond, a principal at NHSCR.

- i research into the patterns of diseases - particularly cancer across England and Wales. For cancer, the data on named individuals are received from the regional cancer registries and the patient entry in the register is flagged. This can sometimes be a very lengthy process. The team actually saw a patient record being annotated in respect of a cancer diagnoses dating back to 1983. Mr. Pennington stated that this length of delay was the exception.
- ii to hold and re-direct the medical records of the dependents of service personnel when they are removed from the list of their local G.P. For this service M.O.D. defray part of the cost.
- iii longitudinal study of the population.
- iv migration analyses: NHSCR send a daily list of changes in FPC lists (by computer tele. line transmission) to vital stats at Titchfield. This is the raw input to the migration analyses carried out by Pop Stats 1 & 2.

Mr. Hewes enquired as to whether or not there was any formal agreement between the DHSS and NHSCR in respect of the tasks carried out by Southport. Mr. Pennington said that he thought that there was, but that he was unsure as to where it was kept

#### Performance Measures

Mr. Hewes asked about performance measures and how - if at all - DHSS took account of them. Mr. Pennington described some current measures of performance eg. - the current document turnround time of about 3 weeks. He said that the overall performance of the NHSCR is judged by the FPC's and that they are content with the service that they receive. He concluded by stating that in his opinion, the activities and performance of NHSCR did not suffer in any way by not being part of DHSS.

#### Resources

Mr. Marland asked whether or not in the context of the R.G.'s resource allocation for DPCS as a whole, resources could be taken away from Southport which DHSS would then have to replace in respect its position as the resource supplier and captive customer for Southport's services. Mr. Pennington replied that he was not aware of problems that might arise in that respect.

Mr. Hewes asked in what respect resources were tied to performance and if Mr. Pennington discussed this with DHSS. Mr. Pennington stated that the only recent cuts in resources had been imposed by central Government, and he described the background to the halting of the cervical cytology work and of the subsequent saving of 130 staff.

## Possible Transfer of NHSCR to DHSS

Mr. Pennington stated that NHSCR holds a great deal of confidential information. This includes medical records, details of sex changes, drug addiction data etc. The B.M.A. is very concerned that the information is fully protected and not used for non medical purposes - so jeopardising the Doctor patient relationship, and would be against any move of the NHSCR to DHSS. He added that as the NHS is so full of restrictive practices, the B.M.A. might also fear that DHSS would be tempted to use the information to monitor the performance of NHS practitioners.

A further important consideration in deciding the future of NHSCR concerns the use of the primary register (ie. the 1939 census data) for epidemiological purposes. The R.G. must currently assure himself that the data is only used properly for those purposes.

## Potential Uses of NHSCR

Mr. Pennington summarised some other potential uses of NHSCR data.

- i To advise DHSS Newcastle of deaths in the population. Since the abolition of the death grant DHSS are unable to monitor deaths in the pensionable population. The R.G. has stated that he is prepared to make the information available to DHSS but only with statutory legislation.
- ii Criminal investigations and information made available to the courts in the cases of social security fraud. The DHSS and LCD are now involved in the relevant aspects of data protection.
- iii The development of national identity numbers for use in social security, child benefit, pensions etc. Mr. Hewes agreed to take the matter up with the R.G.

M.W. Marland

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M.W. Mariand

*Mr Dyche*

Miss Pace

## MACHINERY OF GOVERNMENT REVIEW

During his recent visit to Southport Mr Hewes asked to see the agency agreement between DHSS and OPCS to cover the NHSCR operations.

While there may be other documentation elsewhere in OPCS the only relevant paper in my files is a carbon flimsy of a letter from Ministry of Health to the RG in March 1951; I have had it re-typed and enclose a copy.

I suspect that this will turn out to be the only documentation of any value to the Review although perhaps Internal Audit may have discovered other papers when the recent Audit of NHSCR was made.

*M L Pennington*

M L Pennington  
30 June 1986



MINISTRY OF HEALTH,  
WHITEHALL,  
LONDON, S.W.1.

Health Ref. 94156/1/50

6th March, 1951

Sir,

I am directed by the Minister of Health to refer to his letter of the 13th December last and to say that in addition to the measures at present being taken by Executive Councils and the Central National Registration Office at Southport to eliminate the inflation in the records of persons on doctors' lists, he has had under consideration the steps necessary to obviate as far as possible renewed inflation occurring in the future.

In this connection the Minister has decided that a Central Register of persons on doctors' lists should be set up and that with the exception of transfers of persons following changes of address occurring within the area of an Executive Council, all transfers and all new entrants to the National Health Service should be notified to the Central Register: also that in lieu of the present arrangement whereby notifications of names of persons leaving the National Health Service, whether by reason of death, emigration or enlistment in H.M. Forces are received by the Executive Councils from the Central National Registration Office, such notifications shall in future be sent by the Central Register to Executive Councils.

I am asked to request that you will be good enough to form and operate the Central Register on the Minister's behalf as an adjunct to the Central National Registration Office at Southport. Presumably you will arrange to treat the Central Register as an "allied Service".

It will be appreciated that if a Central Register is to be of the utmost use in achieving the objective in mind it should begin to operate from the date of the commencement of the central clearance operation under E.C.L.6/51, ie 2nd April 1951.

I am, Sir,  
Your obedient Servant,

(Signed) M.I. Michaels.

The Registrar General,  
Somerset House,  
Strand, W.C.2.

M. Dawson M. Dyche  
for file

10/29/06

From: R A C HEWES

Date: 7 July 1986

~~DM~~  
MISS PACE

cc Mr Dyche  
Mr Marland

**HIPE/HES/KORNER AND ALL THAT**

1. On reviewing my papers I conclude that I am still not totally clear about all of these developments and think it would be helpful to get it down on paper.
2. As I understand it, RHA's have in the past provided a 10% sample of data to OPCS under HIPE; statistics derived from this data have been passed to DHSS and others. In Scotland there has instead been a 100% enquiry (handled by Dr Heasman or by SHHD?). RHA's have also provided MHE data (including names and addresses) direct to DHSS to process. In future and following the Korner report HIPE and MHE will be replaced by HES, a 100% data set. This will comprise both clinical and management data. Anything that is pure management data will go to DHSS the rest via OPCS.
3. I am sure this is a deficient description, but perhaps by setting it down it will help to indicate the gaps in my knowledge!

~~DM~~

R A C HEWES

~~Mr Hewes~~

In Scotland 100% HIPE available at regional level has been handled centrally by Dr Heasman at CSA although previously located within SHHD.

The new post-Korner information will include management & clinical data at 100%. Management data will go to DHSS. Clinical data (referred to as HES) will be processed at OPCS.

Both HIPE & HES data are used/will be used by OPCS in the analysis of 'medical' matters as well as providing data for outside customers.

DMpace 8.7.86

cc Mr Dyche  
Mr Marland

FROM: R A C HEWES

Date: 7 July 1986

*amp*  
~~MISS PACE~~

cc Mr Dyche  
Mr Marland

**NHSCR**

1. On reviewing my notes, I see that I recorded the funding of the NHSCR at Southport as follows:

DHSS	- 60%
OPCS	) 'contributions' to costs (presumably covering
Welsh Office	) the balance of 40%)
MOD	)

2. In addition I understood that medical research projects are undertaken only on a basis that covers costs, except where they are specifically for DHSS.

3. Is there in fact a trading account for NHSCR which would enable this picture to be painted more clearly?

*12A*  
R A C HEWES

~~Mr Hewes~~

Does the attached help?

*Jmlace*

10.7.86

cc Mr Dyche  
Mr Marland

OPCS SOUTHPORT OVERALL SPEND AND FUNDING 1985/6

£1,000

	DHSS	OPCS	WO. MOD
Staff costs	2,106	856 <sup>a</sup>	100 (WO) 163 <sup>b</sup> (MOD)
GAE	527 <sup>c</sup>	614 <sup>d</sup>	23 (WO)
EFA	295	150 <sup>e</sup>	15 (WO)
Admin	105	-	5 (WO)
Sub totals	<u>3,033</u>	<u>1,620</u>	<u>316</u>
Total			<u>4,969</u>
% of total cost	61	33	6

NOTES

- a. Calculated on an average of 146 OPCS staff to 378 NHSCR staff
- b. Based on agreed manpower levels and not altered according to staff actually used
- c. Includes £293,000 payment for registration services
- d. Calculated from actual outturn less GAE figure of £191,000 included in DHSS GAE figure of £527,000
- e. Estimate on an average of 20 EFA staff not covered by DHSS EFA for 40 staff



cc Mr. Pallant  
R. Dyke  
Mrs. Page

10/29/03

M65 for file

10/29/06

Office of Population Censuses  
and Surveys  
St Catherines House  
10 Kingsway  
London WC2B 6JP

Telephone: 01-242 0262. extn 2139

From: Mr A.R Thatcher C.B  
Director and Registrar General

14 July 1986

**MANAGEMENT IN CONFIDENCE**

Mr R A C Hewes  
Government Offices  
Room 61/E3  
Great George Street  
London SW1P 3AL

Dear Bob

**REVIEW OF OPCS**

When we met on 9 July, you told me the general line of your current thinking and asked me to let you have any reactions from Malcolm Pennington and Bob Barnes.

As regards the NHSCR, I think that you already know the main arguments. Taking a long-term view, this year's liaison problems with the Treasury and DHSS should not be hard to cure and seem relatively minor in comparison with the questions about confidentiality and data flows; but you will be discussing these soon with DHSS so I will say no more at this stage.

On the Social Survey side, Bob Barnes has three main reactions:

- (a) An inter-departmental group to consider the programme for ad hoc surveys is quite an attractive idea. If properly operated (by the CSO?) it could help to solve several problems - including the question of repayment.
- (b) There is no objection in principle to making more use of private computer bureaux for processing the social surveys. Private computer bureaux have been used in the past but the problem was that they were very expensive, so in recent years the policy has been to use only our own staff. However, circumstances change and we may be entering a period when Computer Division will be hard-pressed to meet all the impending demands. We would not want to prejudice the current plan for a VAX computer; but if that proves inadequate, then the use of bureaux could certainly be considered again.
- (c) As regards the repayment system for ad hoc surveys, we have just sent a document to the Treasury which contains a very useful summary of the developments following the Merchant Report. A copy is enclosed.

I do not recall actually raising this in relation to SSD - I did mention it in relation to Census  
M65

I hope that this will be helpful.

Yours sincerely

*Rogon*

A R THATCHER

3/165

## REVIEW OF OPCS

File  
10/29/06

Note of a meeting held on 18 July 1986, at Alexander Fleming House

Present: Mr M Fairey      DHSS  
                  Mr Hewes              Review Team  
                  Mr Dyche                "      "  
                  Miss Pace                    "      "

1. Mr Fairey is Director of Planning and Information, NHS Management Board and was previously Regional Administrator of the NE Thames RHA.
2. Mr Fairey explained that managerial relationships between DHSS and the NHS would be made stronger and more explicit in the next few years. The aim was to provide more rationally arranged data about the service with which to drive and control a regular planning cycle.
3. He explained that there was considerable apprehension among clinicians about clinical data and its possible misuse by DHSS. These fears were somewhat irrational but nevertheless existed. He quoted the general objection by the BMA to the transfer of even the most basic data between FPCs and District Health Authorities. DHSS has given undertakings to the profession on the way data will be assessed and even went to the lengths of using one RHA to carry out on behalf of DHSS work on performance indicators which required access to individual AHA data. Mr Fairey did not think the view of the BMA was likely to change in the foreseeable future.
4. Mr Fairey considered that any proposal to move any part of, or the whole of, OPCS directly within the DHSS umbrella would meet with profound opposition from the medical profession.
5. Mr Hewes explained that the team had examined the Scottish system where medical statistics were the responsibility of the CSA (part of the NHS). Mr Fairey knew of no plans for a similar development in the English NHS structure and generally felt that such a move would in any case be against the main thrust of current policy to devolve functions. (cf. Supply Council recently abolished).
6. Mr Fairey described relationships with OPCS on Korner implementation as close. The Joint Consultants Committee (of BMA) had been directly involved in the Korner developments and although it might be managerially easier for DHSS to have direct control over the Hospital Episode Statistics System, it was extremely convenient to use OPCS as the data collection point. This provided a workable system that is acceptable to the medical profession.

D M PACE (Miss)

22 July 1986.

## REVIEW OF OPCS

File  
10/29/06

Note of a meeting held on 24 July 1986 at DHSS, Alexander Fleming Hse.

Present: Dr J Metters      Head of Research Management Group  
               Dr M Smith  
               Ms S Moylan

              Mr Dyche              Review Team  
               Miss Pace              "              "

1. Dr Metters explained that very little medical or social research was done within DHSS. DHSS and/or the Medical Research Council commission such work from non-Government researchers and sometimes OPCS. He saw the DHSS research role as not dealing with the analysis of routine statistics unless any obvious gap in knowledge was capable of being filled by research. He quoted the example of DHSS sponsored work by the National Perinatal Epidemiological Unit to draw together the whole range of already available data on births (and criticised OPCS for not having drawn together the different datasets).
2. Dr Metters explained that MRC was one of the 5 Research Councils overseen by the Advisory Board on Research Councils and financed from the Science Vote under the control of the Secretary of State for Education. The MRC was generally responsive to research initiatives but recently had been more active in setting out, in an annual statement, areas where research was needed. Demarcation between MRC and DHSS has only recently been clarified and the two bodies now worked closely to avoid any duplication of effort/resources.
3. Dr Metters described the NHSCR as an essential national tool for research and felt strongly that there was a continuing need for such work. He described OPCS as a department standing separately whose independence and integrity was less threatened than any main policy department such as DHSS. If NHSCR were to be moved under the direct control of DHSS, considerable difficulties would be raised over the handling of the confidential data. He was not able to point to any specific justification for the anxiety on confidentiality but had been aware of regular challenges over the DHSS handling of confidential abortion data. Although a ring fence existed around only a handful of the CMO's staff who handled personal abortion data, DHSS had not been able to take on the processing of the forms and OPCS had been the appropriate body to undertake this work.
4. Dr Metters suggested that if NHSCR had to be moved from its present location, it might be a possibility to run it as a special health authority (i.e. a 99th FPC) and he thought this would largely overcome the possible confidentiality objections from the medical profession. He saw the continuation of links with other OPCS data sources as 'detailed consequentials' which were not insuperable. If because of the FPC computerisation the NHSCR were to become redundant for FPC purposes, Dr Metters would himself, on behalf of DHSS divisions, expect to marshal arguments to justify the continued need for research purposes.

5. Dr Metters said that the collection of statistical morbidity data was more or less exclusive to OPCS but was critical of the apparent inflexibility of OPCS in responding to customer needs. He suggested that OPCS was not always aware of the policy relevance of the data collected although he accepted that changes in data collected to reflect short-term needs might in the longer term provide a less comprehensive/less useful stock of information. (It is often hard to predict what data is needed in the long term.)
6. Ms Moylan was concerned that legal restrictions on the release of individual data e.g. from the Census meant that customers had to rely on OPCS resources, which were limited, to achieve certain analyses. She said that increasing use was being made of the OPCS Longitudinal Study (e.g. it is an important source of data on employment and health) but found it aggravating that current statistical modelling techniques which required access to individual data were inhibited by the legal constraints.
7. DHSS praised the work of SSD (although acknowledging that response time was often long) and felt that the expertise at SSD should not be broken up. DHSS used SSD for survey work on matters sensitive to government or where only SSD were able to draw on sufficiently large resources. They also used SSD to examine research problems, to question methods and to advise in the use of private companies. It would be difficult for SSD to judge the use of the private companies if they were to be in direct competition.

D M PACE (Miss)

25 July 1986.