LETTERS

Use of children's accident and emergency department for infants

The study by Ms Bedford and her colleagues of the reasons for the use of the accident and emergency department at the Queen Elizabeth Hospital for Children in Hackney¹ brought back memories of a similar, though less extensive and unpublished, study I carried out when I was working in the same department 40 years ago (1951-2). Regrettably, I no longer have the data I recorded and presented to a medical meeting at the hospital but my recollections are reasonably clear. Indeed, I have frequently referred to that experience in talks I have given in my subsequent years in general practice.

There were differences, mostly in the case mix. For example, in those days we saw a relatively large proportion of children with infectious fevers. Diarrhoea in infants (true gastroenteritis) was much more severe and breast feeding was a rare exception. Rubella, pertussis, roseola, and primary tuberculosis were seen commonly, especially in infants; in older children streptococcal infections of the tonsils were commonly seen but, rarely, scarlet fever (which I saw fairly often in general practice in the 1970s). Pink disease was common, but mercury teething powders were still in regular use. I also saw two or three cases of tuberculous meningitis. Surgical emergencies were common in infants, as were intussusception and pyloric stenosis, and, in older children, acute appendicitis. All three diseases are now seen less frequently.

But more relevant than the differences are the similarities. Then, as now, most of the children, especially the infants, had medical and social problems which are well within the competence of a general practitioner (GP), working today with the other members of the primary care team. Nevertheless, however large the numbers attending inner city (and other) accident and emergency departments, it is only a small proportion of the total number of patients, including children, seen by GPs.

I agree with Bedford and colleagues that the commonest reasons for parents going to accident and emergency with their children are because either they want a second opinion (even though this is not the best way to obtain one) or because they still retain the belief that hospitals are the place to go to when you are ill (and in pre-NHS days were, unlike GPs, free). It is these misconceptions that need to be resolved.

To do this we need to focus our education on the needs of all three parties involved, not just the members of the primary care team, including GPs. Our hospital colleagues need to understand how primary care is usually provided and why accident and emergency departments are so often misused. But, even more

importantly, we all need to explain to the users of the health service how they should best do so.

Perhaps we might get together – GPs, accident and emergency consultants, health visitors, and community doctors – together with representatives of community health councils to discuss better arrangements for out of hours care: where better to start than with a joint audit.

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- 1 Bedford HE, Jenkins SM, Shore D, Kenny PA. Use of an east end children's accident and emergency department for infants: a failure of primary health care? *Quality in Health Care* 1992;1:29-33.

Accreditation in general practice

I read with interest in your first issue (March 1992) the article by Denis Pereira Gray on accreditation in general practice.¹ He concluded that accreditation is now inevitable in medicine both for individual doctors and their work settings and that the issues now are who, how, and when.

The organisational audit programme at the King's Fund has recently started looking at these issues with regard to primary health care. In January 1992 we set up a project to test the feasibility of introducing organisational standards into primary health care. We are also developing a monitoring system to determine compliance with these standards. Nine pilot sites have now been selected from England, Wales, and Northern Ireland which encompass various organisational arrangements (for example, general practitioner fundholders, and combined health and social services boards) and social settings. The sites collectively provide a range of services including community psychiatric nursing, dentistry, district nursing, health visiting, and social work and all include general practice. Organisational standards are being developed by these sites facilitated by the programme.

It is planned that the standards will be ready by September 1992. Between September 1992 and March 1993 the pilot sites will have the task of establishing a programme for implementing these standards, which will provide a practical test of their value. During this period the programme will identify and train health care professionals from the primary health care setting to undertake the surveys of each of the pilot sites. The principal task of these professionals will be to look at measurability of the standards, but they will also give detailed confidential feedback (oral and written) on each site's progress towards meeting the standards.

The surveys will be completed by the end of June and will be followed by an evaluation of the various stages of the project. This will involve discussion with the different working parties, staff within the health centres, and the surveyors. The

standards and the monitoring process will be revised on the basis of these discussions and further pilot sites identified. Many have already expressed interest. The practical experience of the project and the lessons learnt will be the subject of a conference which is scheduled to take place in June 1993.

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- 1 Gray DP. Accreditation in general practice. *Quality in Health Care* 1992;1:61-64.

Auditing audits

In the course of our work as audit assistants for Wiltshire Medical Audit Advisory Group we have been indebted to Derry *et al* for their ideas on coding stages of the audit process.¹ However, our experience has led us to use two additional criteria for assessment.

Derry *et al* coded the six stages of the audit cycle thus: I choose topic, II set target standards, III observe practice, IV compare performance with targets, V implement change/plan care, VI repeat cycle once (VI) or regularly (VIr). The possible levels of audit activity were then defined by the codes achieved: full audit, five or six codes present; partial audit, codes I and III present, plus either II or V; potential audit, codes I and III present; planning audit, topic chosen (I) and definite intentions for audit; and no audit, no stages present.

Thus under the Oxfordshire interpretation "full audit" could be achieved by completing five of the six stages. However, we feel that failure to complete the cycle, specifically by omitting stage VI, might result in the implemented changes or the written plans for future management being accepted without validation. Indeed, we have uncovered several examples of this precise problem, and we suspect others. Accordingly, we suggest adding a category "completed audit" with the criterion satisfied if all six codes are present. We have retained the "full audit" criterion to acknowledge the work performed by practices which have included all but one of the six stages.

In view of the findings of the North of England Study of Standards and Performance in General Practice that the standard setting process helps to secure improvement in performance,^{2,3} we have introduced a further criterion called "planned audit" (the presence of codes I and II) to acknowledge practices which had moved on from naming the topic of their audit (that is, planning audit) to the often difficult stage of setting standards.

Using this system and information obtained from visiting the practices and from a simple tick box form sent to all practices, we established that by 1 April 1992 the best current audit from each of our 85 practices in Wiltshire satisfied the