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at the Queen Elizabeth Hospital for Children in Hackney brought back memories of a similar, though less extensive and unpublished study I carried out when I was working in the same department 40 years ago (1951–2).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 have no data I had 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 the studies 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). Pneumonia 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 central 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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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 (Vlr). 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 not being accepted by users of the service and thus result in the unmet needs 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 more usual stage of setting standards.

Using this system an 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

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 (anonymously 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 that is scheduled to take place in June 1993.

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following criterion: 8% complete audit, 7% full audit, 31% partial audit, 13% potential audit, 15% planned audit, and 22% planning audit. At that time 4% were performing no audits, but this has subsequently been reduced to 0%. We now have two new categories are compatible with the system described by Derry et al and we hope they will prove useful to others. We agree that the usefulness of this systematic coding system will be to provide information on the progress of audit in the county and to identify those practices in need of help in pursuing their audits. We use the coding method to help us to focus our activities more effectively in facilitating the development of audit in Wiltshire and not in a point scoring or punitive fashion.

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BOOK REVIEWS


As the NHS takes its first faltering footsteps into the new era the need for comprehensive outcome measures becomes clear. Nowhere is the need more acute than in rehabilitation and disability medicine. Evaluation is urgently needed, both to identify efficacious intervention and to convince potential purchasers of its cost effectiveness. Whether for clinical use, research, audit, marketing, or any other reason, measurement is mandatory.

Not that there has been any shortage of attempts at measurement. On the contrary. Nearly every self respecting rehabilitation department in the country has developed its own scale for this or that – Frenchy, Northwick Park, Nottingham, Oswestry, Rivermead, to name but a few (and only on this side of the Atlantic). There are scores of scales, in different types of impairment (motor sensory, cognitive, and emotional); scales for the different levels in the World Health Organisation model of illness (impairment, disability, handicap); and scales which impact the address of disease on the patient, and on those around them, scales which are disease-specific, and scales which are more general. To use a musical metaphor, some scales are almost chromatic in their compactness and attention to detail, while others give an arpeggio-like span of the subject. Knowing which to use can be the biggest problem of all.

Derek Wade’s new book is an answer to our prayers. Not only does it act as a reference guide to the comet of outcome measures in medicine, but it also gives specific advice on the choice and use of different measures. Many will be familiar with the difficulties, having read a research article, only to discover that the outcome measure used is unrecognisable from the one we would have thought to be in Swedish. Validation, if undertaken at all, has usually been published in a subsequent issue, etc. The fourth section of this heavy sent book gives full details of over 100 measures accompanied by the author’s comments on the characteristics (reliability, validity, etc) of the scale.

In a book which attempts to outline the available choices in an unbiased fashion one might expect to be left with yet another wealth of information and little clear guidance. But not so. In chapter 12, the author lays out very clearly his own choice of measurements and the specific circumstances of his two units (one an acute rehabilitation centre, the other a young disabled unit), always with his eye on economy and relevance. The book will be invaluable for anyone involved in service provision, audit, evaluation, research, or planning future services for patients with neurological disability.

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In the 1970s audit was a term that was used rarely in medical parlance in the United Kingdom. In 1980, however, the BMJ brought audit to the attention of many in the medical profession by publishing a series of five introductory articles by Charles Shaw. Drawing mainly on his own experience and knowledge of quality assurance in the United States, Shaw summarised the key principles of audit and, incredibly, in two short papers he was able to document the audit activity in hospitals and general practice in Britain. His paper on the acceptability of audit was written against a general background of decided lack of enthusiasm and suspicion of audit among doctors.

When writing “Looking forward to audit”, Shaw probably did not realise that he would have to wait almost 10 years for Audit in Action. In the almost 10 years between Shaw’s paper and the publication of this book, the author’s thesis that auditing is a necessary and useful component of quality assurance is becoming more widely accepted. Indeed, it is becoming imperious that any medical organisation should audit, and the focus of the book is clearly on the mechanics of how it should be done.

I have two reservations. The first concerns the structure of the book. Audit, unfortunately, is discussed as a one-way traffic, from the organisation to the individual. This is, I think, a misrepresentation of the situation. The other reservation is for sections 4 and 5. These two sections cover the management of audit, which is an important area, but one which already has well-established texts like the one by the BMJ. This book is stronger in its coverage of the early chapters on the need for audit, the ethical and legal aspects, and the development of the audit process. It describes audit in a clear and straightforward way.


Hugh Koch’s excellent book goes much further than the usual basic text on quality, which is often “soft” in its approach and leaves people wondering: “That’s all very well, but...”. It comes much more from his consultancy work and so is grounded in practice and refreshingly aware of all the connections between total quality management and the big issues of quality assurance and auditing.

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