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at the Queen Elizabeth Hospital for Children in Hackney¹ brought back memories of a similar, though less extensive and unpublished, study I carried out when I was working in the same department 40 years ago (1951-2).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

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 audit, but this has subsequently been reduced to 0%.

Our 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 medical audit in Wiltshire and not in a point scoring or punitive fashion.

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- 1 Derry J, Lawrence M, Griew K, Anderson J, Humphreys J, Pandher KS. Auditing audits: the method of Oxfordshire Medical Audit Advisory Group. *BMJ* 1991;303:1247-9.
- 2 North of England Study of Standards Performance in General Practice. Medical audit in general practice. I. Effect on doctors' clinical behaviour for common childhood conditions. *BMJ* 1992;304:1480-4.
- 3 North of England Study of Standards and Performance in General Practice. Medical audit in general practice. II. Effect on health of patients with common childhood conditions. *BMJ* 1992;304:1484-8.

BOOK REVIEWS

Measurement in Neurological Rehabilitation. Derek T Wade (pp 408, £50, £25 pb) Oxford: Oxford University Press, ISBN 0-1926218-07, 0-1926195-43 pb.

As the NHS takes its first faltering footsteps into the new era the need for comparable outcome measures has become 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 – Frenchay, Northwick Park, Nottingham, Oswestry, Rivermead, to name but a few (and only on this side of the Atlantic). There are scales for different types of impairment (motor sensory, cognitive, and emotional); scales for the different levels in the World Health Organisation model of illness (impairment, disability, and handicap); and scales which address the impact of disease on the patients 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 many of the commonly used assessments 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, of discovering anything about the outcome measure used. The original scale turns out to have been published in a journal or book which is not readily available and proves, when it does arrive, to be in Swedish. Validation, if undertaken at all, has usually been published in a subsequent issue, etc. The fourth section of this heaven sent book gives full details of over 100 measures accompanied by the author's comment 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 in 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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Consultant in Rehabilitation

Audit in Action. Richard Smith, ed (pp 245, £10.95 inland, £13.00 abroad) London: British Medical Journal 1992. ISBN 0-7279-0317-9.

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 was able to document total 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 until audit really took off. In the mid 1980s there were isolated pockets of activity among several groups – for example, the Royal College of Radiologists' multicentre audits of the use of routine diagnostic procedures, the Lothian surgical audit of mortality and complications after surgery, the Royal College of General Practitioners' practice activity analysis, and the Confidential

Enquiry into Maternal Deaths. Much good work was carried out, methods were explored, and a small cadre of individuals became experts at the dos and don'ts of audit, while publishing sporadically in the general and specialist medical journals.

After publication of the government's white paper *Working for Patients* in 1989 audit exploded onto the scene, and the *BMJ* responded to the fervour by including a special section on medical audit. In this section articles were published dealing with many aspects of audit; some of these, along with Shaw's early papers, are now brought together in *Audit in Action*. In 30 chapters surgeons, physicians, specialists in public health medicine, audit officers, sociologists, and others, mainly from the United Kingdom, provide a rich insight into audit.

An appropriate organisational framework is often the key to success in audit, and this is addressed in an early section of the book. What is the role of regional specialty subcommittees? How should an individual clinician get started? What should audit officers do? In the following section on "Making audit happen", some methodological issues are addressed – for example, techniques of reviewing medical records and surveying patient satisfaction. Here the book emphasises two important features of audit not widely taken on board in the United Kingdom – namely, setting audit objectives and the use of explicit criteria of good practice. This latter approach is one way of orienting the emphasis of audit from simply collecting data to making improvements in the quality of care. Clinicians wishing to do this would be advised to concentrate on Shaw's chapter on criterion based audit and use Bhopal and Thomson's form, described in a later chapter, as a means of educating themselves about audit when reading papers.

The final two chapters on total quality management, by Berwick, Enthoven, and Bunker from the United States, take us forward from the narrow confines of medical audit to the concept derived from industry that striving for improved quality, not just maintaining the status quo, should pervade every aspect of the organisation and be an ideal that is incorporated into everyday practice. Such a philosophy is not quite with us in the NHS but *Audit in Action*, as well as providing some useful insights into audit, may help to move us in that direction.

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Total Quality Management in Health Care. Hugh Koch (pp 119, £60 pb) Essex: Longman, 1991. ISBN 0-582-07695-1.

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