Improving Health Outcomes
VOLUME TWO - Full version
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Heart disease and appropriate admission in Barking and Havering

Geographical Area covered: Barking and Havering
Focus: Case studies focusing on the use of national indicators

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Editorial comments on how case study is linked to improving health outcomes: (also published in Volume 1)

Watts and Meredith found considerable variation in coronary heart disease mortality within their localities. To improve health outcome effective interventions need to be in place within districts and be used correctly. However, they also need to be used on the appropriate people. They investigated a rise in emergency admissions to hospital and found an increase in the number of episodes associated with coronary heart disease. They set up a study to investigate the management of patients with suspected acute manifestations of coronary heart disease presenting to hospital and whether there were clinically appropriate alternatives to hospital admission for some of the cases. To examine mortality variations within the localities and possible variations in access they will be looking further at public perceptions of general practice to help them understand why there is apparent under use of general practitioner services.

Watts and colleagues also describe their overall use of nationally based population based health outcome indicators within their health authority. The indicators have in some circumstances stimulated detailed strategic reviews, and led to the setting up of multidisciplinary focus groups. The health authority calculates the indicator values for their localities.

Abstract (also published in Volume 1)

Reduction in coronary heart disease mortality is one of the principal Health of the Nation targets. In Barking and Havering, a health authority in East London, we found considerable variation in coronary heart disease mortality in our localities. Furthermore, when we investigated a rise in emergency admissions to hospital we found a steady increase in the number of episodes associated with coronary heart disease. We set up a study to investigate whether patients with suspected acute manifestations of coronary heart disease presenting to hospital were being managed appropriately and whether there were clinically appropriate alternatives to hospital admission for some of the cases.

We took a seven day random sample of 126 patients from urgent referrals to an accident and emergency department or outpatient department of an acute general hospital, whether sent by their general practitioner, self-referred or from direct medical admissions. The cases in the sample were grouped on the basis of the clinical presentation into 50 ‘scenarios’. A panel of 4 general practitioners and 4 hospital clinicians determined blind the appropriate management of the scenarios. We then used the case notes of the sample to determine the appropriateness of admission to hospital and initial management.

All patients in scenarios for which the panel considered admission appropriate were admitted. Only 1.6% of patients where the panel felt that outpatients investigation was more appropriate were admitted. However, 41% of patients were in scenarios where the panel was in disagreement over the need for admission. They agreed that medical assessment, investigation and possible referral was needed. The general practitioner was considered the best person to undertake the assessment, yet two-thirds of these patients self-referred to hospital and so by-passed the gate keeper role of the
general practitioner.

We concluded that between 12% and 21% of admissions to hospital for patients with suspected acute manifestations of coronary heart disease could be avoided if an experienced physician were more readily available to undertake urgent assessments of referrals to hospital.

We will be looking further at public perceptions of general practice to help us understand why there is apparent under use of general practitioner services. This might help us understand some aspects of mortality variations.

**Introduction:**

**Why this clinical area was chosen:**

Coronary heart disease is the single most frequent cause of death in both men and women in England (DOH 1992) and accounts for a large number of consultations in both primary care and accident and emergency departments. Its management is important because there is potential for reducing morbidity and mortality. Reduction in mortality is one of the principal Health of the Nation Targets (DOH 1992).

Barking and Havering is a health district in East London stretching from the river Thames into Essex. The district is divided into seven localities, comprised of five or six local government wards. We used population health outcome indicators (DOH 1994) to describe the district’s position relative to the national average. We extended the indicators using locally derived data, to cover seven localities and the local government wards in the district. This allowed us to derive within-district comparison and trends in mortality (Congdon 1993). Mortality from coronary heart disease was very close to the national average (Table 1).

**Table 1: Age standardised coronary heart disease mortality 1990/92**

<table>
<thead>
<tr>
<th>Age</th>
<th>Barking and Havering (per 100,000)</th>
<th>England (per 100,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;65 years old</td>
<td>50.4</td>
<td>55.6</td>
</tr>
<tr>
<td>65-74 years old</td>
<td>863.3</td>
<td>867.7</td>
</tr>
</tbody>
</table>

This unexceptional picture hid considerable variation by as much as 50% among the localities (Figure 1). Furthermore, for people aged 65 - 74, there was a worrying rise in mortality.

There were also differences in access to tertiary care. We found that the rates of coronary artery bypass grafts were relatively lower in those areas where mortality from coronary heart disease was greater.

**Figure 1: Coronary heart disease mortality rates ages 45-65 years in Barking and Dagenham 1980-1990.**
There are no local estimates of the frequency of non-fatal coronary heart disease in the district. In the most recent national survey of morbidity in general practice, 2% of all people and 8% of those aged over 75 years consulted for ischaemic heart disease (OPCS 1995). In a study of 3,039 adults attending two accident and emergency departments, one in inner London and the other in a provincial hospital, 4.6% of those seen and 29% of those admitted to hospital were classified as having circulatory disorders (Jankowski and Mandalia 1993).

Chest pain is a common presenting symptom of coronary heart disease. There are many causes of chest pain, but the public tends to equate the symptom with heart disease (Inman 1994). With evidence for the beneficial effects of thrombolysis for acute myocardial infarction and the recognition of the importance of access to monitoring and defibrillation, hospital management of acute myocardial infarction has become part of the accepted standard of care (de Bono and Hopkins 1994). Not only do health care staff and the public expect patients with ‘heart attacks’ to go to hospital, but the importance of seeking help from the emergency services as soon as possible has been emphasised (de Bono and Hopkins 1994). General practitioners have traditionally played an important ‘gate keeping’ role in assessing whether or not a patient needs to be referred to hospital (Toon 1994). Contacting the general practitioner has been shown to delay the time from the onset of symptoms to the administration of thrombolysis and admission to a coronary care unit in acute myocardial infarction (Ahmad et al. 1992). Even so, the question of whether all persons with acute chest pain should be assessed in accident and emergency departments remains controversial (Kennersley et al. 1991). Recommendations for the investigation and management of stable angina by a working group set up by the Joint Audit Committee of the Royal College of Physicians of London and the British Cardiac Society (de Bono and Hopkins 1994) include access to a cardiological assessment for all newly-diagnosed cases of angina in patients under the age of 70 years. They state that immediate referral is only recommended for persons with unstable or crescendo angina.

In March 1994 we set up a multi-agency steering group involving hospital consultants and managers, general practitioners, public health and health authority managers, to examine the rise in emergency medical admissions. This was because physicians were finding themselves under increased workload pressure. Additionally, these admissions involved the health authority diverting additional resources into the main acute hospital. We found that the increase was across all age groups and that there had been a shift in work to the main hospital. We also found that the largest increase was consistent and steady in the number of hospital episodes associated with coronary heart disease, that is to say acute myocardial infarction, arrest and arrhythmia, heart failure, angina, athero-sclerosis and chest pain, and syncope and collapse. We decided that there should be a detailed local investigation focusing on the management of patients with symptoms suggestive of coronary heart disease.

Further information that was required:
We set up a study to determine

- whether district residents with suspected acute manifestations of coronary heart disease referred or admitted to hospital (including self-referrals) were being managed appropriately; and
- whether there were clinically appropriate alternatives to admission to hospital for some of the cases.

We selected a random sample of patients from district medical admissions and urgent referrals to the accident and emergency department or the outpatients, whether seen by their general practitioners or self-referred. We defined ‘urgent’ cases thought by the general practitioner or patient to require hospital assessment within two days. We included persons who had any of the following complaints: chest pain/angina, possible myocardial infarction, heart failure, acute breathlessness, dizziness/syncope/collapse and palpitations/arrhythmia. Patients had to be 16 years or over and resident in the district. We included a random sample of seven days during October and November 1994, and chose study days by random selection of one day per week so that each day of the week was represented. We collected data over seven weeks. Cases were identified from accident and emergency log and admission books in which all casualty attendances and admissions were recorded. Additionally, on each study day, the consultants holding medical and geriatric clinics were contacted to ask whether they had seen any urgent outpatient referrals for the complaints under investigation.

We omitted two important groups of patients from the study: (a) those presenting to other hospitals and (b) those who did not go to hospital but were either managed by their general practitioner or did not seek medical help. As 79% of emergency medical admissions of district residents in 1993/94 were to the local acute general hospital, the omission of those who attended other hospitals was unlikely to introduce serious bias. Furthermore, the hospital draws most of its patients from our resident population. The exclusion of patients who did not attend hospital was more serious but it was decided that the difficulties of identifying patients with acute symptoms in the community would render the study impracticable. We intend to monitor the mortality of patients with acute myocardial infarction who do not get admitted to hospital.

We obtained the notes for all patients and determined eligibility for inclusion. We collected data prospectively because a pilot study had revealed serious difficulty in retrieving casualty cards for patients who had not been admitted and outpatient clinic lists did not identify urgent referrals separately. We used specially designed data collection forms. The following were recorded: place and time first seen, source and type of referral, age and sex, history of the present complaint, relevant past medical history, recorded findings from the initial physical examination, results of investigations available at the time of assessment, such as electrocardiographs, chest radiography and simple blood tests, whether or not the patient was admitted to hospital and, if so, the type of ward and level of monitoring provided.

Clinical scenarios

With the advice from a physician, patients in the sample were put into groups of similar cases based on the clinical presentation, past medical history, broad age category, main clinical findings and the results of initial investigations. The guiding principle was that cases in the same scenario would be likely to require the same investigations and level of care; the diagnosis reached by the assessing clinician was not used in the categorisation, nor whether or not the patient was admitted. This resulted in the preparation of 50 clinical scenarios. This was an attempt to simulate the RAND method of providing a panel with all the indications for a particular intervention (Brook et al. 1986).

The questionnaire

We developed a brief questionnaire to assess the clinical needs for each scenario. This asked whether the patient needed:

- medical assessment and if so by whom;
- any investigations and if so which;
- a specialist opinion and if so how urgently and from whom;
- nursing care and/or monitoring and if so the level required;
- the appropriateness of hospital admission. This was judged on a scale from one (most
appropriate) to nine (least appropriate).

The panel

The function of the panel was to reflect the opinion of those local clinicians who deal most with the complaints under investigation. The panellists consisted of four general practitioners, two nominated by the Local Medical Committee and two by the Medical Audit Advisory Group (MAAG), and four hospital clinicians, one was a medical registrar who was working with the physician on the panel, and the other three were the consultant in emergency medicine, a consultant in care of the elderly and a general physician who we invited to join the panel. The panel reviewed the questionnaire to ensure that questions and instructions were clear so that interpretation would be done in the same way. We then gave to the panellists the 50 clinical scenarios in random order. Independently of each other they were asked to complete a questionnaire on the clinical needs for each scenario. We analysed the results and identified areas of consensus and disagreement. These we presented to and discussed with the panel.

Although there were differences of opinion about the management of different scenarios, in particular between general practitioners and hospital doctors, the panel decided that the majority view was the best reflection of their combined opinions.

For the appropriateness of admission, however, consensus was not the objective. Rather we sought areas of clinical agreement and disagreement. We analysed the appropriateness scores using the RAND method (Brook et al. 1986). We classified the responses into ‘inappropriate’, ‘appropriate’ and ‘equivocal’. All the ‘equivocal’ scenarios were ones in which the panel was in disagreement.

Panel opinion on the scenarios

All agreed that all the patients discussed in the scenarios needed medical assessment. There were, however, considerable differences of opinion between the general practitioners and hospital clinicians as to who should assess the patient first: general practitioners favoured their own assessment in the majority of scenarios; hospital doctors favoured casualty officer assessment initially. The majority of the panel felt that further investigation was needed in all scenarios. Referral should be immediate to the medical team on call. With only five scenarios was a medical outpatient referral thought appropriate. Professional nursing care and cardiac monitoring was thought to be less important by general practitioners than hospital doctors. More general practitioners than hospital doctors thought that hospital admission was inappropriate. For 19 of the scenarios, there was closer agreement between the groups that admission was appropriate.

Data validity studies:

The method we used for this study was based on the RAND approach (Brooks et al. 1986) which was developed for the assessment of technological interventions such as coronary artery bypass grafting (Gray et al. 1990). We had to adapt it to the evaluation of admissions in the following ways:

- Admissions to hospital do not have clearly defined risks and benefits. Panellists were not only considering the costs and benefits to the individual patient but also the appropriate use of limited resources;
- In the RAND method, the indications were all judged twice. To repeat the exercise would have asked a great deal of busy clinicians and so the judgements were based on one assessment only and panel discussion;
- Instead of drawing up a comprehensive list of possible clinical indicators for the intervention which was normally done as part of the RAND method, the scenarios were based on a sample of hospital presentations;
- Although the method used was not formally evaluated, it is at least as good a reflection of medical opinion as any of the review instruments that have been ‘validated’, using the majority view of a panel of three experienced physicians as the gold standard (Getman et al. 1981). This study used 4 general practitioners and 4 hospital clinicians.

An important criticism of this work and both the RAND and utilisation review approaches is that they only consider the opinion of doctors. The views of other health professionals and the public should have a say in defining appropriate care. Work of this nature should be seen as addressing only one aspect of health service evaluation. The question of whether what the clinicians thought was appropriate, is also what patients would wish, was not answered by this work.
Summary findings from initial work:

We found 126 cases who fulfilled the study criteria. There were slightly more men (54%) than women (46%). Just over 70% of the cases were over the age of 50 years. The majority of the cases were self referred. Only 30% had been referred by their general practitioner, usually to the medical team on duty. There was a higher referral rate from general practice during surgery hours (9 am - 6 pm) than outside that time or at weekends reflecting the availability or perceived availability of general practice. The patient was admitted in 61% of cases with a higher rate in those referred by their general practitioner compared with those who had presented themselves.

All the patients in the scenarios for which admission to hospital was considered appropriate were admitted. This is summarised in Table 2. This was 43% of the sample. We found good agreement among panellists about the management of these cases and practice conformed well with the panellists' views of what should happen.

Table 2: Appropriateness of admission

<table>
<thead>
<tr>
<th>Appropriateness of admission</th>
<th>Admitted</th>
<th>Not admitted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate</td>
<td>2</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>3%</td>
<td>37%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equivocal</td>
<td>21</td>
<td>31</td>
<td>52</td>
</tr>
<tr>
<td>70%</td>
<td>63%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate</td>
<td>54</td>
<td>0</td>
<td>54</td>
</tr>
<tr>
<td>100%</td>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>77</td>
<td>49</td>
<td>126</td>
</tr>
<tr>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Only 1.6% of patients in the inappropriate category were admitted. The panel thought that outpatient referral and investigation would be more appropriate.

Patients in the equivocal category (those scenarios where the panel was in disagreement over the need for hospital admission) constituted 41% of the sample. The patients concerned had potentially serious conditions. The panel agreed that they needed medical assessment, investigation and, in some cases, referral to a physician. They also agreed that the general practitioner was the best person to undertake the assessment and refer as necessary. However, two-thirds of these cases were self-referred and so bypassed the general practitioner. Only one third had been referred to hospital by their general practitioner. Cases falling into this category included:

- persons with angina of recent origin;
- persons with palpitations and a history of myocardial infarction;
- persons with long-standing angina who had a ‘funny turn’ (e.g. brief blackout or fall) associated with chest pain;
- previously healthy middle-aged persons with chest pain that was not typical of ischaemic heart disease but which had worrying features such as radiation associated with exertion or a blackout, and in whom no abnormality was found on physical examination or basic investigations;
- persons with pleuritic chest pains;
- persons with chest discomfort, productive cough and breathlessness;
- persons with exacerbation of relatively mild chronic obstructive airways disease.

These are diagnostic categories about which clinical decision-making is difficult and there is no consensus as to whether or not hospital care is appropriate. Hospital doctors tended to think that a higher proportion should have attended the hospital than the general practitioners, but what little evidence we have about the value of hospital care in these grey areas tends to support the primary care view. However, because the majority who presented to hospital were not referred, the gate-keeping role of the general practitioner was bypassed.

Some of those who were self-referred may have come to casualty because they were not satisfied with their general practitioner, although this is not likely to account for many (Coast et al. 1995). Twelve to thirteen per cent may not have been registered with a general practitioner (Davison et al. 1982). Most are not likely to have attempted to contact a general practitioner before going to casualty (Singh 1988).

We found very little inappropriate admission in this study, but between 12% and 21% of admissions might be avoided. This is compatible with the Hospital Admissions Study in Bristol which found that some 10 - 15% of admissions might be avoided if alternative forms of care were available, e.g. a community hospital or same-day outpatient assessment (Coast et al. 1995). Even so, this represents an important workload. If extrapolated to a whole year, these would represent 500 avoidable admissions. A summary of the findings are presented in the
Changes which were made:

The public health department, who undertook this work, drew up a number of recommendations. We presented them to the steering committee and they were accepted. We also presented the findings to the senior management team of the health authority who endorsed the recommendations. We have discussed the findings with the Local Medical Committee and with the MAAG. As a result of this, the authority’s commissioning intentions for 1996/97 included a major focus on coronary heart disease prevention and management.

The detailed recommendations were as follows:

- There should be local implementation of the Royal College of Physicians guidelines for the management of angina. This has been taken up by the MAAG;
- A district audit of the communication between general practitioners and hospital clinicians in relation to urgent cases should be carried out to determine what the difficulties were and how these might be addressed. This should include assessment of access to advice from consultants and urgent referrals. It should also include the communication of information about patients seen in the accident and emergency department, whether or not they were referred. This forms part of the quality improvement programme planned by the health authority;
- A local study of why people with medical problems self-refer to the accident and emergency department was needed. This should include determination of the proportion registered with a general practitioner, whether they have attempted to contact a general practitioner and their perception of the urgency of their problem. We will discuss this with the hospital as part of the clinical audit programme;
- When on call, the duty senior medical house officer or registrar should not have other scheduled responsibilities from which they cannot withdraw readily. This will enable a more responsive assessment of accident and emergency cases. There should be a properly evaluated trial of consultant physician sessions in the accident and emergency department. These are being assessed by the hospital as to their feasibility;
- There needs to be involvement of the public in the debate over the role of hospitals and inpatient care for diseases such as coronary heart disease. Primary care needs strengthening and the public educated so that at least within the working day general practitioners are consulted more appropriately. This is part of the general debate we are having with the local community as part of the acute services strategy, which is out for public consultation;
- A study of the local perceptions of general practice should be set-up to understand why there appeared to be under-use of general practitioner services, compared with other parts of the country. We are setting up a working group to look at coronary heart disease specifically. We will include this as part of our work;
- There needs to be involvement of primary care in the commissioning of accident and emergency services, so that they are more responsive to general practitioners’ and patients’ needs. We will be discussing this with the director of accident and emergency how this might be achieved. The trust is appointing a director of primary care who may be able to facilitate this.

Further work is needed to understand the reason for variations in coronary heart disease mortality across the district. We are planning a comparative study of high and low mortality areas and will be looking for opportunities to strengthen health promotion.

How changes will be monitored:

We feel the most direct method for monitoring changes will be a repeat of audit of hospital presentations twelve months after implementation of the changes. We will focus on the ‘equivocal’ scenarios identified as most amenable to changed management. Measures of success will be:

- a reduction in presentations to the hospital accident and emergency departments of this category of patient;
- an increased referral to consultant specialist clinics for urgent assessments from general practitioners;
- a reduction in inappropriate admissions to hospital of patients in this category.

This audit will be combined with a general practice audit focusing on two aspects:

- compliance with the guidelines of the Royal College of Physicians on the management of angina;
- the primary care management of patients falling into the ‘equivocal’ category as a joint audit with hospital clinicians.
The public health department will monitor population mortality from coronary heart disease. Mortality from acute myocardial infarction will be monitored linking hospital admission with subsequent mortality after discharge. This involves data linkage of hospital episode statistics (HES) and National Statistical Office (NSO) mortality using death notifications. This work is well advanced. Mortality without admission to hospital will also be monitored. This will be detailed to locality populations in the district, against the district average, and to individual general practices.

**Resource Implication:**

To undertake this study we used the dedicated time of a senior member of the public health department to facilitate and organise the work. We also had commitment from senior clinicians in hospital and primary care in contributing to panel discussions. Careful preparation for panel meetings kept this to four occasions.

The introduction of assessment of medical cases in accident and emergency departments by an experienced physician who might be a better clinical judge than junior staff has financial implications. It involves timetable alterations so that the medical registrar is not expected to undertake clinics and routine ward rounds when on duty. This could be achieved and at minimal cost if firms had regular ‘take-in’ days. The burden on senior physicians available for consultation would not pose an onerous work-load and might improve patient management.

The suggestion of a chest pain clinic for urgent cases would require staff and equipment and would duplicate facilities already available in the accident and emergency department and outpatients. There are references to a few such clinics (Norrell et al. 1991) but none has been evaluated for cost-effectiveness.

On the benefit side, there is the potential to reduce the number of inappropriate admissions to hospital by 500 per year. This would represent a considerable saving to the NHS.

**Practical lessons learnt:**

Involvement of senior clinicians in hospital and primary care early in the planning and conduct of this study was essential to enable the study to be carried out. The commitment of Hospital Management, the Local Medical Committee and the Health Authority helped to create a project framework in which the study could be undertaken. A steering committee guided its progress. This also ensured the cooperation needed from a wide range of accident and emergency and medical records staff. The question to be investigated was seen to be important as there had been a rise in emergency admissions and there was little local information available on the reasons for this.

Perhaps most important was the recognised need to explore the interface between the hospital and general practice. The opportunity for examining this in detail was presented in a way which allowed the full expression of professional knowledge and practice. Clinicians were dealing with everyday clinical situations to which they could relate. This also enabled them to exercise their problem-solving skills in formulating solutions to the study’s findings. We will be building on this in our work to strengthen the primary care focus for health commissioning.

Our approach to clinical effectiveness involves working with general practitioners and hospital clinicians to develop evidence based clinical guidelines around coronary heart disease clinical management. Our focus is on implementing these as part of a Research and Development funded project.

**Conclusion:**

**References:**

A) Heart disease and appropriate admission in Barking and Havering

Barking and Havering Health Authority (1994). Bringing Health to Life in Barking & Havering 1994:


Organisational Context:

Barking and Havering Health Authority was formed on 1 April 1996 with the merger of Barking & Havering DHA and FHSA. The Health Authority is in the process of finalising its acute services strategy, the aim of which is to rationalise the provision of acute services in the local Trust which should help to release resources for improving primary care and community services.
The Public Health Department in Barking and Havering has been using population outcome indicators ever since they first became available. Each year, the Directorate issues several documents to guide the commissioning process and one of the documents issued is based on the latest HSI package. A section is devoted to the population outcome indicators and health objectives are defined based on the indicators. The topics chosen for detailed strategic review are also partly based on the relative position of the district in the population outcome indicator profile.

The health authority has adopted a population health outcome approach in focusing on key health problems and monitoring improvements in health (Barking and Havering HA 1994). The public health department has refined the outcome indicators so that they are available for the seven localities in the district (Congdon 1993). This enables us to be more precise as to where local problems are greatest. We do regular six-monthly monitoring of indicators (based on admissions data) and present this to the health authority. We use indicators in a number of different ways:

- For some indicators e.g. diabetes and hip fractures we use a focus group approach to examine local epidemiology, service profiles and to identify problems. These groups involve key stakeholders such as hospital clinicians, general practitioners, Trust managers and service users. Recommendations for action are made to health authority managers.
- For other indicators we adopt a population approach and work with commissioning managers in deciding what appropriate action is needed in consultation with the local authority, NHS Trusts, general practice and the community. In one such project (Singleton 1994) we addressed the health and social problems in a disadvantaged locality in one of our boroughs. Senior officers of the health authority, local authority (including the Chair of Social Services), NHS Trusts and residents of the locality. The focus was on Health of the Nation including coronary heart disease. We used local epidemiology and a ‘rapid appraisal’ of the community’s expressed needs to guide our decisions. An action plan is currently being implemented and we will be evaluating its effectiveness.
- We also use indicators in the needs assessment work for health strategy development such as older people and cancer.
- We developed a contract debriefing pack so that contract negotiators can be informed of any issues we need to raise with Trusts. This summarises key points arising from needs assessment work. The quality specification in the contract is a useful tool for focusing on general problems such as communication with general practice.
- Each year we produce clinical audit guidelines for NHS Trusts highlighting any areas where clinical audit might provide solutions to problems identified e.g. amputation in diabetes and cancer outcomes. We develop these guidelines from our needs assessment work and also incorporate ideas from key reports emerging during the year; for example, the confidential enquiry into surgical mortality. This forms part of the specification for the clinical audit contract.
- The authority’s commissioning intentions is a vehicle for signalling any major changes resulting from this work, especially where new developments of services are proposed.
- Our clinical effectiveness programme involves working closely with general practitioners and hospital clinicians in developing evidence based guidelines for clinical practice and other ways of getting research evidence into practice e.g. thrombolytic therapy in acute myocardial infarction.
- In conclusion, although there is great interest within the organisation for using outcomes, this interest has not been translated fully into practice because of the lack of good quality data. Another general issue which prevents the use of outcomes in contracting is the lack of clear relationship between structure, process and outcome of care. The provider units incur costs on the structure and process of care and it is difficult to contract on the basis of outcomes, when the relationship between the three is not clear. Further work needs to be undertaken in this area.