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Clinical audit – a proposal

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The best form of psychiatric audit would probably entail carrying out detailed structured interviews of mental state throughout treatment programmes in order to measure clinical effectiveness. In practice this is clearly impossible for busy routine services and will probably be confined to research initiatives. A number of units have attempted to carry out clinical audits subjectively but that clearly has the limitation of bias.

An alternative to using patient or therapist-based information is to use the services of local general practitioners as professional monitors of the work done by psychiatrists. The ability of GPs to identify problems within their local mental health teams has already been highlighted by the Stirling County studies which have shown that family doctors are often well aware of specific problems before the specialist teams themselves (Leighton, 1982). Such studies also act as a timely reminder that providing additional resources does not necessarily lead to an improvement in the service delivered. GP review has already been tried with some success in the delivery of psychogeriatric services and indeed structured interviews with the general practitioners were part of the evaluation of the Worcester Development Project (Bennett, 1989). However, the question arises as to whether the process can be adopted to become a routine clinical audit tool which can identify cheaply and accurately the strengths and deficiencies of local psychiatric services.

The study

A new consultant-based psychiatric service providing for a catchment population of around 105,000 people was established in Bassetlaw in 1984 and has been described in a previous account (Kingdon & Szulecka, 1986). There was a significant movement towards the principles of community care and it was decided from the outset that some measure of performance should be in-built. General practitioners using the service were felt to be in a very good position to judge its effects but it was also accepted that their interests might not always be identical to those of their patients.

As those new developments were being introduced the GPs were polled on their views of the existing service. This was done by circulating them with a questionnaire forwarded independently from an outside unit. That approach allowed GPs to reply anonymously, although they were made aware that their comments would be passed on to the psychiatric team. After the service had run for about four years the exercise was repeated with some additional items designed to evaluate subsequent developments. A separate section of the questionnaire invited the general practitioners to provide specific criticisms arising from individual experience of the service and to comment on any ideas they might have for future change.

Findings

Of general practitioners, 65% (n = 55) completed the questionnaire the first time around compared to 48% (n = 39) on the second occasion. Non-respondents were spread widely across practices and it was not possible to identify reasons for their failure to complete the questionnaire. (See Table I).

In the first survey the GPs' main criticisms were based on the limited number of therapeutic modalities available to their patients. They felt that the service as operated then principally offered drug based therapies with few psychological alternatives. It was felt to be divorced from the practical realities of the patients' lives and had little or no ability to respond to acute crises in terms of urgent appointments or admissions. GPs complained that important decisions were made by relatively junior members of psychiatric staff and commented particularly on the lack of expertise shown by psychiatric social workers in dealing with formal admissions.

Three years later the service had made a considerable number of advances in these areas, principally through the introduction of multidisciplinary team working. Nearly all the measures used showed improvement over the period. Nonetheless GPs again lamented the difficulties in getting help in psychiatric emergencies and felt it was still too long before they could get urgent out-patient appointments. Communication overall had improved but there were still difficulties with non-medical members of the psychiatric team. For example, 28% felt that psychologists communicated badly whereas only

TABLE I
GP view of their local psychiatric service

Present psychiatric service is:	*1st survey before 1984*	*2nd survey after 1988*
better from patients' point of view	18	85
convenient for patients	14	87
less stigma for patients	16	56
better organised	12	64
more confidential	22	15
better from GP's point of view	16	87
more convenient for GP	39	79
leads to easier admissions	39	79
is helpful in psychiatric emergencies	37	64
has improved communication	43	64
overall level of satisfaction	31	90
	n = 55	*n* = 39

Percentage of general practitioners who agree with the statement

TABLE II
GP assessment of new service (1988)

The new service is:			
a definite deterioration	*no improvement*	*some improvement*	*definite improvement*
0	5	23	67

	Yes	*No*
CPN communicates well	80	18
CPN service effective	80	15
CPN offers alternative to admission	49	46
Psychology service effective	67	21
Psychology communicates well	60	28
Satisfied with psychologist	50	36

Percentage of GPs who agree with statement (*n* = 39)

18% felt that CPNs did so. Nearly half the doctors (49%) felt that the introduction of community nurses had helped avert admissions and 80% of those who replied believed that the CPN's work was clinically effective. The bulk of criticism was reserved for psychology, in particular the rapid way in which long waiting lists had developed, effectively reducing the benefits of an otherwise very welcome service. Two-thirds of the doctors felt that psychologists' work was clinically effective but only 50% were satisfied with the overall level of care offered. (See Table II).

Despite the introduction of extra team members, there was no significant change in the general practitioners' perception of the clinical time devoted to dealing with psychological problems in their practice or in their referral rate to psychiatrists . They were, however, more likely to refer directly to other psychiatric team members including psychologist, social worker, and especially the community nurse. Interestingly they were less likely to use the services of the health visitor to deal with psychological problems with no change in the role that the practice nurse played in the treatment of these conditions.

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Comment

These surveys provided a great deal of information which had a more local application and could be used to monitor changes as they were introduced. It is disappointing that more GPs did not participate, and indeed could not be persuaded to do so despite repeated efforts. In general further contacts, e.g. telephone calls, were answered politely but not accompanied by completion of the questionnaire. Hostile responses were rare but noteworthy; one doctor expressed the view that he "never replies to outsiders". There clearly is a danger of fatigue on repeated surveys but it was refreshing to see that nearly 40 family doctors were still willing to be involved in the assessment of their local psychiatric services.

It was felt at the outset that anonymity of individual replies would allow for a more accurate reflection of the quality of the service and this of course can easily be preserved by different units carrying out audits for one another. It is of interest to note few GPs would comment directly on the work of individual therapists but did demonstrate a willingness to be open in other equally important areas which can prove very valuable to the unit as a whole. It is obviously important to keep such audits in perspective, particularly as family doctors may have a limited understanding of all aspects of the service. The total cost of both surveys was under £100 which would make this method of audit one of the cheapest available.

Audit of psychiatric services by the GPs who use them is a practical and cheap way of assessing certain aspects of those services. Repeated at regular intervals, for example, three to five years, it might provide a profile of progress that alerts the psychiatrist to problems before they become too serious. The surveys themselves could be specifically designed for local purposes and undoubtedly would develop greater sophistication and precision as they became more widespread. Clearly it is time for psychiatrists to take this on board before an alternative financially-based audit procedure is forced upon us.

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References

BENNETT, C. (1989) The Worcester Development Project: General practitioner satisfaction with a new community psychiatric service. *Journal of the Royal College of General Practitioners*, **39**, 106–109.

KINGDON, D. G. & SZULECKA, T. K. (1986) Establishing a district psychiatric service without psychiatric trainees. *Bulletin of Royal College of Psychiatrists*, **10**, 338–340.

LEIGHTON, A. (1982) *Caring for Mentally Ill People: Psychological and Social Barriers in Historical Context*. Cambridge University Press.

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Psychogeriatric day hospitals: open to audit?

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Day care has been called one of psychiatry's gifts to medicine. The British psychiatric day hospital movement began in the post war years and its philosophy continues to flourish with the decline of institutional care.

Psychogeriatric services often have a day hospital as the cornerstone of multidisciplinary care for the elderly mentally ill. Those who work in psychogeriatric day hospitals do so with a sense of purpose and an impression of benefit. The question of benefit has come to have moral, social, financial and political implications. A sense of 'doing good' is no longer sufficient justification for a service and psychogeriatric day hospitals are likely to become increasingly open to scrutiny.

How can their quality of care be evaluated? Literature over the last 20 years has described and examined the psychogeriatric day hospital movement. It is reviewed here according to Donabedian's three components of any health care service. He described 'structure' as encompassing staffing, building and organisation, 'process' (the activities of health care) and 'outcome' (the results of intervention) (Donabedian, 1966).