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Summative assessment

Sir,

I am surprised that Rhodes and Pietroni (January *Journal*), on discovering that the results in their region for summative assessment were at such variance from the published work,^{1,2,3} immediately chose to criticize a valid and reliable system rather than carry out an internal audit within their own deanery. The only purpose of summative assessment is to identify the GP registrar who is not competent, and the system is set up to achieve this aim. In the video component, the first level of assessment is all about sensitivity, with the two assessors working individually to make a judgement: either that the GP registrar is competent or that there is some doubt. If there is doubt, the videotape is referred to the second level. The aim of the first level is to ensure that all potential GP registrars who could fail are identified. The published work^{1,2,3} has not only shown that 20% of GP registrars will be identified at the first level for further examination, but that, ultimately, around 5% of GP registrars will fail summative assessment. The comparative data for North West Thames is only 1.2% — this finding must surely raise questions as to why such a disparity has arisen.

Fortunately, the United Kingdom (UK) Conference of Regional Advisors have the National Quality Control system, and, for the first year, 20.8% of GP registrars throughout the UK were identified at the first level for referral to the second level in the video analysis, which mirrors the published work. Unfortunately, North West Thames only referred 11.3% from the first to the second level and there clearly is a training/calibration issue within the region, which should be in keeping with their low fail rate. The region also refers fewer candidates to the National Panel than would be expected, and these two factors explain the disparity. Rhodes, although leading summative assessment in

his own region, opposes⁴ the current content of summative assessment.

We have been able to look at the five multiple choice questions and problem-solving tests that were held from September 1996 to September 1997, with a total of 1871 candidates. This is the only objective test taken by all GP registrars. When comparing all the mean percentage scores by regions, the mean for all candidates was 73.64. The GPs in the North West Thames region scored 74.95 and the range of means for all regions differed by only 1.5 marks. This provides unequivocal evidence that there is no difference in the range of abilities of GP registrars throughout the UK. The information demonstrates that there is a training calibration problem within North West Thames, and, as professional educators, I know that they will respond to this problem in a very positive way.

The cost for summative assessment quoted by North West Thames is £775 per candidate. A study of costs has been carried out by the National Summative Assessment Office and almost all regions have costs per candidate of between £425 and £450. North West Thames must look at why their figures are so much more expensive. Comparative data are uncomfortable for those who are different but surely everyone else cannot be out of step.

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References

1. Campbell LM, Howie JGR, Murray TS. Summative assessment - the West of Scotland pilot project. *Br J Gen Pract* 1993; **43**: 430-434.

2. Campbell LM, Howie JGR, Murray TS. The use of videotaped consultations in summative assessment of trainees in general practice. *Br J Gen Pract* 1995; **45**: 137-141.
3. Campbell LM, Murray TS. Summative assessment of vocational trainees - results of a three year study. *Br J Gen Pract* 1996; **46**: 411-414.
4. Rhodes M, Wolf A. The summative assessment package: a closer look. *Educ Gen Pract* 1997; **8**: 1-7.

The feasibility of standardized data collection in primary care

Sir,

Data collection in the National Health Service (NHS) has significant costs¹ and consumes much staff time in primary care.² Despite considerable activity and enthusiasm in general practice,² few data have appeared to aid resource allocation and improve health care. Relevant primary care data can be collected at several tiers of the NHS, but their importance should be judged by their perceived usefulness within primary health care teams. Provided that different data sources can be combined, general practitioners and their teams need only collect information that cannot be gleaned elsewhere.

Sixty-four practices in north-east England, selected by their FHSAs, were invited by post to pilot a minimum dataset over a three-month period. Items requested were data of potential significance for clinical care not collectable elsewhere. Feedback was sent to practices together with evaluation questionnaires. Fifty-three local providers were contacted by letter and followed up by telephone to recover data collected and stored by them.

Twelve practices agreed to take part in the pilot, but only nine, covering 51 650 patients with 30 doctors, submitted a pilot dataset. Practices were unable to capture all of the information requested.

Table 1. Practice questionnaire responses to data feedback (mean Likert scale scores with number of respondents in brackets).

| Topic | Clarity | Accuracy | Usefulness |
|---|---------|----------|------------|
| GP surgery, non-surgery, and out-of-hours consultations per 1000 patients | 4.5 (8) | 4.8 (8) | 4.14 (7) |
| Practice nurse consultations per 1000 patients | 4.1 (8) | 4.4 (8) | 3.5 (8) |
| Appointments missed per 1000 patients | 4.6 (8) | 5.0 (8) | 4.1 (8) |
| Total secondary care referrals | 3.9 (8) | 4.7 (7) | 3.6 (7) |
| Community referrals made by doctor | 4.4 (8) | 4.8 (8) | 2.6 (8) |
| Attached staff intrapractice referrals | 4.6 (7) | 4.4 (7) | 2.8 (7) |
| Doctor intrapractice referrals | 3.9 (8) | 4.0 (8) | 2.4 (8) |
| Asthma morbidity percentage rates using Jones morbidity index | 4.6 (7) | 4.4 (7) | 3.7 (7) |
| HbA1c levels | 4.6 (8) | 4.5 (8) | 3.1 (8) |

Eight of the nine practices provided feedback assessments. Clarity and accuracy were rated quite highly, but mean usefulness scores (scale 0–5) varied from 2.4 to 4.1 (Table 1). Participants felt unsure that all data were complete, but half the practices were willing to continue collecting such data.

Thirteen of the 53 providers responded (25%), but only five of these returned usable data. Similar doubts about the accuracy of data were expressed, and the considerable time and effort necessary for their collation were acknowledged.

We have shown that general practices cannot easily construct meaningful datasets concerning their activity. Our sample of volunteers was clearly small, but if data collection in presumably enthusiastic practices was problematic, the position would be even worse in a representative cohort.

No systematic linkage with other providers' datasets was possible for our participants. To be of real use, and to be worth the expenditure of finite resources, existing data collection needs to be standardized and synthesized to form a comprehensive data model of the activity surrounding general practice, hospital trusts, other providers, and the patients they all serve. Such a process may be useful to promote evidence-based purchasing.³

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References

1. Sullivan F, Mitchell E. Has general practitioner computing made a difference to patient care? A systematic review of published reports. *BMJ* 1995; **311**: 848-852.
2. Newrick DC, Spencer JA, Jones KP. Collecting data in general practice: need for standardisation. *BMJ* 1996; **312**: 33.

3. Pearson N, Brien JO, Thomas H, *et al.* Collecting morbidity data in general practice: the Somerset morbidity project. *BMJ* 1996; **312**: 1517-1520.

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Primary care counselling and the community mental health team

Sir,

Recent papers by Nelson *et al* and Baker *et al* (*March Journal*) on counselling trials in south Wales and Dorset respectively, make interesting reading.^{1,2} Three other recent studies^{3,4,5} also provide conflicting evidence regarding the benefits of primary care counselling. Four of the studies looked at the effect of provision of counselling services on referral to community mental health team staff.

In our own locality, our community mental health team is concerned that patients from practices not having counsellors were being referred at a higher rate than those practices that had the services of in-house counselling. This was confirmed by referral rates of 8.15 per 1000 and 5.65 per 1000 respectively ($P = 0.000$), resulting from a retrospective audit. In a prospective study comparing practices with and without in-house counsellors, I found that patients with apparently similar illness severity and diagnosis (mainly depression) were being referred in fairly high numbers to the community mental health team, specifically for counselling.

In the case of practices not having counsellors, in 63 consultations for new mental health problems, 60 patients were considered suitable for counselling and 39 were referred for counselling, of whom 21 were referred to the community mental health team. In the case of GPs having

counsellors in their practices, of 42 consultations for new mental health problems, 29 patients were considered suitable for counselling and 21 were so referred, of whom 14 were referred to the in-house counselling service and only one to the community mental health team. This is a similar finding to the much larger Dorset and Somerset studies.

My results suggest that, in many cases, practice counsellors are seeing patients of an illness severity and type who, in other practices where no such service exists, are being referred to community mental health teams. I found the figures given by Harvey *et al* for the cost of services (rather quaintly referred to as mean resource utilization) somewhat unrealistic. A more realistic figure is given by a fund manager for a general practice who compared contracts with the community mental health team at £56 each per hour with a counsellor under contract at £25 an hour. This service saved the practice £370 a week.⁶ Similar studies have confirmed this price differential.

The somewhat negative findings of the controlled trials of Harvey *et al*¹ and Friedli *et al*³ contrast with the more positive findings (in terms of counsellor effectiveness) of the Somerset, Dorset, and Winchester/Eastleigh trials. I wonder if this is related to the moderately intensive assessment techniques both in the control and treatment groups, which are quite disproportionate to usual general practitioner intervention, and thereby producing a Hawthorne effect. Another possible confounding factor is indicated by the comment in Harvey's paper that 'despite efforts to obtain this data, the proportion of potentially eligible patients entered into the trial is unknown. If a large proportion of those eligible are not included, the generalizability of the results to the wider population could be compromised.'¹ Also, in Friedli's paper, the author's remark, 'despite our efforts to recruit all suitable patients, some may have declined to take part, or general practitioners may have been reluctant to