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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Acknowledgements

Thanks are due to all the staff from the practices involved in this work for their efforts in collecting data, and to David Newrick for his work on their analysis. The project was funded by a grant from the former Northern Regional Health Authority.

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 if 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

recruit patients to the study.'

It seems that the presence of counsellors in general practice may allow for the management of significant numbers of patients with mental health problems at a relatively low cost within the practice, and therefore allows the community mental health team to get on with the central business of managing those with fixed mental illness.

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Right From The Start

Sir,

The juxtaposition of the article 'Caring for others: consider the emotional issues'[1] with the *Right From The Start* CD-ROM advert in the December issue of the *Journal* prompted us to write with more details of the *Right From The Start* project, which directly addresses many of the issues raised by Dr Angus.

The *Right From The Start* initiative emerged from a recognition of the widespread unhappiness of parents about the way in which they were told about their child's disability. Poor communication was at the heart of the problem.

Convened by Scope, following the launch of the *Right From The Start* report,[2] a working group of representatives from the voluntary sector, medical professionals, parents, and people with disabilities drew up a 'template' of good practice. This template focuses on the values that are at the heart of good communication in this difficult situation: respect for parents, children and childbirth, and positive attitudes to disability.

The *Right From The Start* project recognizes the support professionals need in dealing with their own 'anxieties and vulnerability' if they are to avoid 'denial and avoidance'. The project offers training and discussion opportunities, with parents and disabled people (themselves adequately prepared and supported) playing an active role.

The project has moved on from enjoining better practice to devising action to improve it. A team approach, which should include GPs, is not only advocated, but also demonstrated by the initiative itself. We have been aware throughout of the relevance of the project beyond the specific issue that is our concern. We welcome enquiries about the work that is underway.

The educational initiatives include a video, CD-ROM, good practice guidelines, and regional conferences which will be held throughout 1998.

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Summative assessment

Sir,

We at the Joint Committee are heartened to note the enthusiasm and energy expressed by Dr Cunliffe's letter (March *Journal*). We also note Dr Cunliffe's call for the use of the MRCGP examination as a basic qualification for entry into our discipline in preference to a standard imposed at the other end of the spectrum of ability, represented by summative assessment.

As a regulatory, educational, and standard-setting body, the Joint Committee is as interested as Dr Cunliffe in setting an ever-increasing level of entry into our discipline. The JCPTGP, however, had to work within the confines of legislation and of a professional consensus as to the standards that it is reasonable to impose from time to time.

Before the introduction of summative assessment, there were no standards whatsoever set for entry, and, given the fact that Dr Cunliffe is dismissive of the intellectual challenge set to him/her and colleagues, perhaps it is reasonable to assume that summative assessment is presently pitched at a reasonable level to assess competence. Of course, the MRCGP remains available to Dr Cunliffe and others who wish to demonstrate a higher level of proficiency, and perhaps that is as it should be for the time being.

Many of us in the Joint Committee believe that, eventually, the MRCGP may become a *de facto* requirement for admission into general practice as a principal. That will come about, however, only when general practitioners come routinely to demand this qualification from aspiring partners; this is the situation with other specialties and it would therefore seem inappropriate to introduce legislation only for general practice. In the meantime, the JCPTGP has been pleased to recognize, in principle, that a pass in the MRCGP certainly subsumes and surpasses the standard set by summative assessment.

In general terms, therefore, we have sympathy with Dr Cunliffe's desire for raising standards, we also, however, have a responsibility to introduce change at a rate that is in line with general professional opinion, but always mindful of our responsibility for assuring standards of medical practice for the patients whom we serve.

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Counselling in primary care

Sir,

The paper by Harvey *et al* (March *Journal*) will excite debate in counselling circles for obvious reasons. It seems that only short-term follow-up can be achieved because of loss of subjects with longer follow-up periods. Does this suggest that this group of patients is unduly mobile, or that the farther they are from counselling, the less likely they are to agree to be studied? I would argue that longer-term follow-up is essential so that the likely immediate placebo effects of both interventions, which could be masking a difference, can