In this issue

International lessons in clinical quality and evaluation

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Informatics to improve quality

The issue opens with an editorial reminding us that computers should provide services that support frontline clinical care; and that we need an information strategy that moves us away from complex electronic patient record systems and towards a Service Orientated Architecture (SOA).1

The issue also contains a series of papers which illustrate the role of informatics in improving the quality of clinical medicine. Computerised clinical information systems can process large volumes of data and provide feedback or incentives to improve quality.

The clinical domains in this issue range from BP management, to diabetes, to mental health to community pharmacy. Our papers and lessons in informatics come from around the world, from North America, the UK, Malaysia and Australia.

Better quality markers come from observation over time, and including prescription collection rates

Our first paper shows how more sophisticated data processing may enable the development of better quality targets.2 The authors cite BP management as an appropriate target and collection of prescriptions as potentially one of the more reliable of a basket of potential indicators. The principle of looking at change over time, rather than at a single time point as takes place within the pay-for-performance (P4P) scheme in the UK appears a good one. The rate of collection of prescriptions may be a really important and unexploited measure of quality – and generalisable beyond hypertension; for example my group has described how many people with osteoporosis do not collect their bisphosphonate prescriptions.3 Whilst collecting medicines does not necessarily mean that a patient is taking them, not collecting prescriptions almost invariably means that there is poor concordance with therapy.

Disease registers: checking out the assumption they improve care?

The second paper describes a review of the effectiveness of disease registers as tools for improving quality in diabetes.4 This is an important critical appraisal of the need for such registers. Importantly the review concludes that such registers are important to improve the process (particularly the ability to register, recall, and review) and also the outcome of care. Stone, in her commentary on this piece, reminds us of the importance of ensuring that such registers are of high quality; within the UK issues have emerged about the quality of coding, classification and diagnosis of diabetes.5 This had led to a joint NHS Diabetes and Royal College of General Practitioners’ (RCGP) programme of work known as the “Classification of Diabetes” (CoD) programme.6

International lessons in informatics

The remaining six papers in this edition cover a wide range of important informatics lessons.
Two papers look at the predictive power of data. The first used keywords in the text of referral to predict the need for audiograms. The second reports how the home use of technology and level of expertise predicts the uptake of electronic prescribing in the doctors’ office. Mental health data are complex but can be used to evaluate the impact of a service to improve rates of referral of people with memory problems.

As an informatics community we have scope to considerably improve how we describe and write up the body of knowledge which defines our discipline. For a science like ours where there is socio-technical complexity systematic reviews are complex. We publish a protocol to provide insight into how to go about conducting a systematic review in informatics. We hope this will become a model for future use.

Our final two papers report aspects of quality management: the first is a case study from Australia and reports how feedback raises quality; and finally a study showing how pharmacists prefer using refined and interpreted tertiary rather than primary information.

REFERENCES

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