In this issue

Making health information and communications technology (ICT) relevant and usable for quality improvement and research

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Using health ICT to improve quality

This issue opens with an Editorial exploring another example in informatics where, to quote Voltaire, the prefect (or in this case the precise) is the enemy of the good. 

‘Le mieux est l’ennemi du bien’ (La Bégueule, 1772).

In this case your Editor turns his attention to the failure of pathology laboratories to report numeric values, preferring when proteinuria measures are low to report ‘unrecordable’ or use a ‘less than’ (<) sign. Such text fields remove the ability of practices and localities to audit data; and might even interfere with data collection for national audits. 1

Next in this issue, Cresswell et al., suggest why engagement has been poor in the NHS national programme. 2 More importantly they propose a model of how engagement takes place. Their model suggests that there is a point of engagement, after which there is a variable period of engagement inevitably followed at some point by a point of disengagement. They identify attributes related to each stage; including what actions might support re-engagement.

Using theory of planned behaviour to understand whether a technology is used

We are publishing a protocol using the ‘Theory of Planned Behaviour’ to explore whether doctors do or don’t participate in the online element of an emergency medicine course. 3,4 The theory of planned behaviour explores how an individual’s attitude (positive or negative) towards an action; their perceptions of social or peer pressure to participate or not; and their beliefs about control and ability to complete the task might explain whether they take action or not. This approach might be more broadly applicable in informatics where system failures are common.

Referral patterns and estimating vascular risk in populations

Understanding referral patterns and reasons for referral is important. A paper from Canada, where just under half (46%) of attendances in primary care are referred, suggests that most of the variation can be explained by patient rather than practice factors. 5 If correct, the implications are that the patient mix, not the practice drives the referral rate. This might make the idea of a ‘high referring practice’ a thing of the past.

An important paper by Dalton et al., suggests that extrapolating from survey data about the prevalence of cardiovascular disease can be done through the use of multiple imputation (MI). 6 MI is a statistical process for dealing with missing data. The process of ‘imputing’ is to fill in the missing data entries several times with the imputed values taken from a representative distribution. The multiple imputed values are then analysed and pooled.
Record quality

Three papers describe aspects of record quality: (1) A pilot survey of computerised record transfer in the UK showed mixed results with some practitioners pleased and others less so. Revising and updating records when patients transfer between practices remains a workflow issue. (2) A second pilot study suggests that a data entry clear can significantly improve data quality. Data entry by clerical staff is the norm in much of secondary care – we should consider this as a possibility to rapidly improve data quality in primary care. (3) An update about a research database (THIN – The Health Improvement Network) describes the similarity of the prevalence of conditions in this database with those reported in national quality improvement campaigns.

SNOMED and other terminologies need a support system

Finally, a research letter adds to the critique of Systematized Nomenclature for medicine – Clinical Terms (SNOMED CT) published in Informatics in Primary Care. Roumier et al, suggest that much information is already, and will continue to be coded in other coding systems; of importance to the authors of this letter is the International Classification for Primary Care (ICPC), however their argument would apply to any coding system. They make the case for a Terminology support service or system which would allow ready mapping between coding systems and languages.

REFERENCES

1 de Lusignan S. Auditing quality in kidney disease and diabetes: is the precise the enemy of the good? A commentary on difficulties auditing pathology results containing ‘greater than’ or ‘less than’ signs. Informatics in Primary Care 2011;19(4):189–90.
2 Cresswell K, Morrison Z, Crowe S, Robertson A and Sheikh A. Anything but engaged: user involvement in the context of a national electronic health record im-
7 Ellis B, Howard J, Dedman D and Hawking M. Perceptions on the quality of records received via GP2GP electronic transfer service: Pilot online questionnaire study. Informatics in Primary Care 2011;19(4):233–40.
11 de Lusignan S, Chan T and Jones S. Large complex terminologies: more coding choice, but harder to find data–reflections on introduction of SNOMED CT (Systematized Nomenclature of Medicine – Clinical Terms) as an NHS standard. Informatics in Primary Care 2011;19(1):3–5.
12 de Lusignan S. Codes, classifications, terminologies and nomenclatures: definition, development and application in practice. Informatics in Primary Care 2005;13(1):65–70.