Practical approaches to monitoring care in acute myocardial infarction

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This conference was held at the Royal College of Physicians on 28 September 2000 by the Clinical Effectiveness and Evaluation Unit and the Faculty of Public Health Medicine.

The Commission for Health Improvement (CHI) hopes to bring about demonstrable improvements in the quality of NHS care in England and Wales, by examining clinical outcomes, not only in the medical sense, but also by taking account of the patients' views on outcome and clinical effectiveness. These may differ from those of their doctors. This has become more pressing since attention has been drawn to the considerable variations in standards of care in the NHS, particularly in the acute specialties such as cardiology – jolting the confidence of the general public.

Outcome measures for acute myocardial infarction

The assessment of clinical outcome of acute myocardial infarction (AMI) should include, besides case fatality rates, information from population studies, clinical data and the views of patients and their carers. Currently, AMI is analysed in terms such as admission and re-admission rates, thirty-day and one-year mortality rates. Pain- and door-to-needle times have become essential information and paramedics need to be involved in collecting these data.

A recurring theme of the meeting, particularly expressed by medical staff present, was that of the need to improve the accuracy of clinical coding of AMI and acute coronary syndromes.

Mortality league tables indicate trends in mortality, which, fortunately, is rare in AMI, though AMI is a frequent cause of admission. Such league tables may highlight poor clinical management and identify weaknesses that can be audited and monitored to show progress and improvement. Accurate coding is vital, especially of the cause of death, with AMI being overused as a diagnosis for patients dying unexpectedly of unrelated illnesses. Other variables, such as ethnicity or areas with large numbers of holiday makers, also influence league tables.

While social and economic influences may explain the difference in care for AMI patients, though not justify it, the value of keeping an audit of the process

Conference programme

- **The Commission for Health Improvement and clinical governance**
  Dame Deirdre Hine
- **Clinical outcome indicators – an overview**
  Dr Alastair Mason
- **Uses and abuses of mortality league tables**
  Dr Robert West, Reader in Epidemiology
- **League tables: how to avoid the play offs at the end of the season**
  Dr Iain Findlay (Consultant Physician and Cardiologist)
- **Should we use process or outcome measures to assess quality of care?**
  Dr Jonathan Mant, Senior Lecturer, University of Birmingham
- **PTCA in acute myocardial infarction and the measurement of quality**
  Dr Raphael Balcon, Consultant Cardiologist
- **Data collection: how to make possible what is desirable?**
  Dr Robin Norris, Honorary Consultant Cardiologist
- **Central Cardiac Audit Database**
  Dr David Cunningham, Project Manager, Central Cardiac Audit Database
- **Data analysis and utilisation**
  Dr John Birkhead, Consultant Cardiologist, Associate Director CEEu
- **National benchmarking – a support service for clinical governance**
  Dr Mike Pearson, Director CEEu
- **Effective local and regional strategy co-ordination – how to make it happen**
  Professor RK Griffiths, Regional Director of Public Health

of care and outcome in AMI is that it enables informed policy and decision making, identifies poor performance and provides information for consumers.

The central cardiac audit database

This has been running as a pilot project since 1996, collecting data from a number of centres including surgical and paediatric cardiac units and more recently statistics on AMI. It is hoped that it will be compatible with local data entry software to enable it to track individual patients as well as providing population information.

Is the collection of reliable information on a nationwide scale feasible? Delegates at the conference reported being seriously frustrated by the difficulties created by inaccuracies of coding and other problems relating to local variables, both technical and sociological. They also questioned just how operator friendly the system really is and whether it is appropriate for small units.

The conference left us with questions about what a successful outcome actually is and whether patients and their doctors measure success in the same way. Since the conference, I have met several colleagues who felt it had not fulfilled their hopes of finding out 'how to do it'. They were already committed to collecting accurate data on AMI but were still unsure how best to 'set the ball rolling'. This is a feeling echoed in general practice. More such study days are needed to promote confidence in dealing with this important subject.