Are you shocked by this report?

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Key words

blood pressure measurement, defibrillator, diagnostic and monitoring equipment, Holter monitor, survey

Br J Cardiol 2008;**15:**119

A key component of the UK General Medical Services (GMS) contract, which was implemented in April 2004, is the quality and outcomes framework (QOF). Since April 2006 a total of 655 points are available in the clinical domain; 55% are directly for cardiovascular disease (including atrial fibrillation), hypertension and diabetes. The anticipated inclusion of peripheral arterial disease (PAD) in the recently revised QOF failed to materialise; this is of particular concern given the wealth of evidence supporting its inclusion.

General practitioners (GPs) on average have achieved high QOF scores in the clinical domains related to cardiovascular disease and it therefore may appear surprising that the direct provision of diagnostic and monitoring equipment within general practice is very variable as highlighted in this week's article by Alison Day *et al.* (see pages 141–4).

Within the survey there were some very notable findings. It might have been expected that general practices would have achieved close to a 100% attainment figure for the possession of a static blood pressure (BP) machine. There were no comments made regarding the usage split between automated and mercury/aneroid machines or further questions regarding the availability of cuffs in different sizes. A reported 45% of practices possessed an ambulatory BP machine, a figure considered unexpectedly high by the investigators and surprising in view of National Institute of Health and Clinical Excellence (NICE) guidance on this subject. The high adoption of this test is likely to reflect the perceived usefulness of this test by GPs, allowing more accurate assessment of particular patient groups, especially those with suspected white-coat hypertension. The caution relating to the high provision in practices of Holter monitors is well made. Many cardiac networks do not allow direct access to this service for the investigation of patients with palpitations and it is common for this to be a consultant requested test.

Within the organisational domain of the GMS contract there is a requirement for a yearly update for basic life-support training/resuscitation to occur, however there is no specific reference made to provision of automated external defibrillators (AEDs). Almost half the practices in this survey had an AED, possibly following earlier guidance from the resuscitation council that an AED programme is indicated if the incidence of cardiac arrest makes it likely that an AED would be used at least once every five years. More recent guidance has suggested more universal provision of AEDs in primary care including dental practices. It would be interesting to know if all primary care out-of-hours providers have defibrillators.

From this review of equipment provision and maintenance within primary care the suggestions by the authors for some form of equipment guidance is well made. How should this be done and who by?

On closer reflection we should also acknowledge the improvement in service that has occurred since the introduction of the National Service Framework (NSF) in 2000. Cardiac networks in many areas have developed pathways of care suggesting when, where and by whom diagnostic tests and treatments should be provided. The increasing burden of disease and other competing conditions necessitates that available resources be used in the most appropriate and cost-effective way in order to benefit the most patients. General practice is now beginning to develop more corporate working and the advent of practice-based commissioning and payment by results linked to the 18-week wait initiative will push this agenda further forward

Conflict of interest

DM is a member of Target PAD.