understanding the
clinical indicators
2007
Purpose of this guide?

This is a short guide to the 2007 clinical indicators report. It summarises – for both health service staff and the public – the key points from the full report.

What is a clinical indicator?

A clinical indicator is a quantitative measure that provides some information about a specific aspect of health or healthcare at a particular time.

An example of a clinical indicator is the survival rate of people following emergency admission to hospital with a heart attack.

Why are clinical indicators produced?

Healthcare systems require a range of data to monitor, and facilitate improvement of, the quality of clinical services they provide.

Clinical indicators, drawn from centrally maintained national datasets, can flag up areas where further investigation and quality improvement activities might be beneficial. More detailed information from local (and often clinically led) data systems is also required to run safe and effective clinical services.

However, clinical indicators do not provide a direct measure of performance, and so cannot be used to make reliable external judgments about the quality of patient care.

The clinical indicators report is published to i) highlight the important role that data should play in providing safe and effective clinical services, and ii) provide data that can be used to stimulate reflection on clinical practice. We expect NHSScotland to use these indicators to examine its performance and, where necessary, to take appropriate action to improve the delivery and outcomes of patient care.
What topics are covered?

Clinical indicators for the NHS in Scotland were first published in 1993, and this is the twelfth in the series of clinical indicators reports. Each report covers a range of health topics, and the 2007 report presents data on:

- depression
- arthritis, and
- gastrointestinal conditions.

Focusing on these topics dovetails with current health policy in Scotland\(^1\)\(^2\), which puts an emphasis on the management of chronic conditions and on healthcare provided in the community.

This guide presents a summary for each topic, including the key patterns in the data at national level. More detailed information, including that for individual NHSScotland organisations and regions of the country, is included in the full report.

The full report is available, in both printed and electronic format, from NHS Quality Improvement Scotland (NHS QIS). In addition, the figures from the full report are available to download – together with some supplementary tables – from the website of the Clinical Indicators Support Team at the Information Services Division of NHS National Services Scotland:

www.indicators.scot.nhs.uk
Depression

Background

Depression is a common mental illness, characterised by low mood and loss of interests. Depressive episodes affect about 1 in 5 people at some time in their lives.

The severity of depression varies from person to person. Some are able to carry on with their day-to-day lives without too much difficulty, whereas for others the illness is very distressing and disabling – and potentially life threatening.

It has been claimed that depressive and anxiety disorders have overtaken unemployment to become Britain’s biggest social problem – yet the scale of the problem is not widely acknowledged, due to the shame and the stigma associated with mental illness3.

While depression is common and costly (in both human and economic terms), it is also treatable. However, it is acknowledged that many people do not have timely access to the full range of interventions and supports for depression.

Current evidence-based guidelines4,5 recommend that most people with depression have access to psychological therapy. It is also recommended that antidepressants are considered for treatment of moderate and severe depression.

Other approaches to treatment range from lifestyle changes and social care, to electroconvulsive therapy for the small proportion of people with depression whose illness is particularly severe.

NHS QIS is currently developing standards for an integrated care pathway for depression and, through Scottish Intercollegiate Guidelines Network (SIGN), is developing a guideline on the non-pharmacological management of mild to moderate depression in primary care.
Key findings

It is estimated that about 6 women in 100 in Scotland consulted a GP for depression, double the rate for males. This rate rose steadily as the level of social deprivation increased.

The rate at which antidepressants were dispensed in the community has increased dramatically. It more than quadrupled between 1992-3 and 2005-6, rising from 19 to 85 defined daily doses⁶ per 1,000 population. This increase largely reflected the prescribing of selective serotonin reuptake inhibitors – newer types of antidepressant recommended because they are less likely to cause side-effects. The steep growth in antidepressant prescribing was not matched by an increase in people consulting general practice for depression.

There are no nationally consistent data about waiting times for, or the delivery and outcomes of, psychological therapies in Scotland. The Scottish Executive made a commitment to increase the availability of psychological therapies⁷ – and such data are needed to inform service redesign and monitor clinical outcomes.

Only a small proportion of people with depression receive care in hospital. The rate of people discharged from a psychiatric hospital for depression was about 1 in 1,000 of the population.

Electroconvulsive therapy was given to a very small percentage of people with depression whose illness was very severe, and improved clinical outcomes were observed in the vast majority (93%).

The majority of general practices reported that, following the SIGN guideline, the Edinburgh Postnatal Depression Scale was used in the postnatal period as part of a screening programme. However, only about 40% of practices reported that psychological therapy was routinely offered to women diagnosed with postnatal depression.
Arthritis

Background

Arthritis is the term for a group of diseases that cause pain, swelling, stiffness, and loss of motion in the joints. Symptoms vary from person to person, although they can be disabling and impact severely on quality of life, eg affecting a person’s family/social life and also their ability to work.

There are many different types of arthritis, the most common of which is osteoarthritis, followed by rheumatoid arthritis. There is no cure for either disease but – once diagnosed – there are effective treatments to control pain, improve joint function, and reduce the worsening of the disease.

Lifestyle changes (eg low impact aerobic exercise, weight loss) can help some people with osteoarthritis. The disease can also be treated with medicines – including simple painkillers, and non-steroidal anti-inflammatory drugs which relieve pain and stiffness. Joint replacement surgery can be considered for some people who experience severe symptoms (eg unbearable pain, inability to walk).

In 2000, SIGN published a guideline on the management of early rheumatoid arthritis. Lifestyle changes can help people with rheumatoid arthritis take care of their joints, although it is recommended that the disease is treated early with disease modifying anti-rheumatic drugs. These delay the progression of the disease and thus help symptoms improve over time. Non-steroidal anti-inflammatory drugs can also be prescribed to relieve symptoms of rheumatoid arthritis more quickly – and some people with the disease may benefit from treatment with newer drugs sometimes called biologic therapy.

There is a lack of a Scotland-wide approach to collecting and using data to monitor, and support improvements to, services provided for people with inflammatory arthritis. NHS QIS is currently funding an audit in relation to the SIGN guideline on rheumatoid arthritis.
Key findings

Between 1998-9 and 2005-6, the rate of people consulting a GP for osteoarthritis decreased by about a third – and this rate was consistently higher for females than for males. These broad trends were also observed for rheumatoid arthritis, although the overall consultation rate was somewhat lower than for osteoarthritis.

The rate at which standard non-steroidal anti-inflammatory drugs were dispensed in the community decreased between 1998-9 and 2003-4, before increasing again. Conversely, the rate of prescribing Cyclo-oxygenase (Cox) II selective inhibitors\(^8\) increased rapidly from the late 1990s, peaking in 2003-4, before falling sharply.

Between 1996-7 and 2005-6, the rate of prescribing disease modifying anti-rheumatic drugs increased year-on-year, rising from 529 to 1,012 defined daily doses\(^6\) per 1,000 population.

The rate of hip replacement was fairly constant between 1996-7 and 2001-2, and then increased in those aged 65 years and over. The rate of knee replacement increased between 1996-7 and 2005-6.

For females, the rate of admission to hospital (day cases and inpatients combined) for rheumatoid arthritis decreased between 1997-8 and 2002-3, and then steadily increased. The admission rate for males was notably lower than for females, and was more constant during this time period.

The rate of admission to hospital for rheumatoid arthritis for areas of greatest social deprivation (15 per 10,000 population) was about double that for the most affluent areas (7-8 per 10,000 population).
Gastrointestinal conditions

Background
The term dyspepsia, meaning ‘bad digestion’, refers to a range of symptoms arising from the upper gastrointestinal tract – which itself comprises the mouth, throat, gullet (oesophagus), stomach and small intestine. Two of the most common causes of dyspepsia are gastro-oesophageal reflux disease and peptic ulcer disease.

Gastro-oesophageal reflux disease is a condition in which gastric contents are brought back from the stomach to the oesophagus, and sometimes even to the throat and mouth. For some people the reflux of gastric contents causes such frequent and severe symptoms that it is considered a disease. The symptoms can often be treated effectively by a combination of lifestyle changes and drug therapy, in particular a course of acid suppressing medicines called proton pump inhibitors.

A peptic ulcer is a break in the lining of the gastrointestinal tract, usually found in the stomach (gastric ulcer) or the duodenum (duodenal ulcer), the upper region of the small intestine. While peptic ulcers sometimes heal without treatment, they can also result in serious and potentially life-threatening complications, eg bleeding and perforation.

Peptic ulcer disease is most commonly caused by the helicobacter pylori bacterium, and antibiotics can be prescribed to treat the infection and ulcer. The disease can also be induced by pain medications called non-steroidal anti-inflammatory drugs. In these circumstances, an acid suppressing drug (usually a proton pump inhibitor) can be prescribed to relieve the symptoms and allow the ulcer to heal.

In 2003, SIGN published a guideline on the investigation and treatment of dyspepsia in adults[1].
Key findings

Between 1998-9 and 2005-6, the rate of people consulting a GP for gastro-oesophageal reflux disease was fairly constant – while the rate of people consulting a GP for peptic ulcer disease decreased by over 80%.

The rate of prescribing proton pump inhibitors increased year-on-year between 1996-7 and 2005-6, and more than trebled during this time period. This rate increased from 6,486 to 22,815 defined daily doses\(^6\) per 1,000 population.

The rate of admission to hospital for peptic ulcer disease decreased steadily between 1996-7 and 2005-6. This rate increased as the level of social deprivation rose – the admission rate for areas of greatest social deprivation was almost double that for the most affluent areas.

The rate of admission to hospital for gastrointestinal bleeding was fairly constant between 1996-7 and 2005-6 – as was the rate of death from gastrointestinal bleeding.

The rate of admission to hospital for gastrointestinal bleeding increased as the level of social deprivation rose. The rate for areas of greatest social deprivation (14 per 10,000 population) was more than treble the rate for the most affluent areas (4 per 10,000 population).
Where do the data come from?

When a person visits their GP or attends hospital, selected details about their health and healthcare are routinely recorded. This information is needed to care for the person properly. Such information is also valuable for improving healthcare for everybody, for example it helps NHSScotland check that services are run efficiently, and to plan services for the future. Personal health information is kept in the individual’s medical case record folder, or on computer.

How is personal information protected?

The confidentiality and security of all personal information are regarded with utmost importance by NHSScotland. Measures are taken to protect patient confidentiality – all staff working in the NHS are bound by a strict code of confidentiality. In addition, the Data Protection Act gives a person important rights about how their personal information is used. Further details – including guidance for patients and carers on these rights and how NHSScotland uses personal health information – can be found at the Health Rights Information Scotland website:

www.hris.org.uk

Further information

The Clinical Outcomes Group oversees the publication of the clinical indicators report. The Chairman of this group is Dr Dorothy Moir (Director of Public Health, NHS Lanarkshire).

For further information about the 2007 clinical indicators report, please contact:

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References


6. The defined daily dose is the assumed average maintenance dose per day for a drug used for its main indication in adults.


10. Cox II selective inhibitors are a particular type of non-steroidal anti-inflammatory drug, marketed as being less likely to cause gastrointestinal problems but which were subsequently shown to be associated with potentially serious side-effects.

About NHS QIS

NHS Quality Improvement Scotland was established to help improve the quality of healthcare in Scotland.

It does this by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

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