planning permission on grounds of over-provision. Individual homes are tending to become much larger, e.g. over 90 beds, and are increasingly passing from individual to corporate ownership. Financial return, rather than patients' need, could become a determining factor in a patients' management. Empty beds are financially undesirable. The admission of a patient to hospital or their transfer to a more suitable home could be disadvantageous to the current home when a high vacancy factor exists in the area.

When hundreds of dependent elderly are housed in adjacent buildings in areas chosen for available beds rather than personal associations, we are returning to the asylum village, not developing care in the community. We have institutionalised the community!

It has to be said that many of these new and large developments offer excellent care. Choice is desirable and competition should improve standards. Statutory services and the professions need to further clarify relationships with the independent sector as suggested in the College report mentioned above, to ensure the best service for elderly people is developed. NHS and Social Service provision in an area must be proportional to the numbers of dependent elderly not merely to the total elderly population.

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Better use of out-patient and in-patient data in psychiatry: a necessary step towards medical audit

DEAR SIRS

The continued failure to classify psychiatric beds into short, medium or long-stay makes audit and, therefore, effective planning impossible. Superficial scrutiny of one service in Scotland (West Lothian) shows, using nationally derived data, an average length of stay of 220 days which compares unfavourably with the Scottish average of 132 days.

More accurate information can be achieved when the beds are identified by classification. Hirsch (1988) showed for selected assessment units a mean length of stay of 38 days +13. Those for the index hospital were 34.9 days in 1987. If this information was gathered nationally along with standard measures, such as percentage bed occupancy and turnover interval, medical audit is possible.

An internal audit could consider length of stay in specific diagnostic categories and relate these to specific clinical teams. In Scotland nationally first admission rates, while higher than in England, have been fairly consistent for over a decade. There has been a two-fold increase in *readmission* rates. Where there are "blocked" beds are rehabilitation services utilised at the correct time? Are current rehabilitation units dealing with an appropriate clientele?

A similar exercise would help in determining services for the elderly. For Scotland the national returns for the category *geriatric assessment beds* were a mean length of stay of 39.9 days with a turnover interval of 4.1 days. For the *psychogeriatric* assessment unit in West Lothian the mean length of stay was 52.7 days with a turnover interval of 4.7 days which compares favourably with the national average for Geriatric Assessment Units. Yet again national data classify all beds for the elderly as one in psychiatric hospitals.

Finally, and of greater significance in determining community-based services, the production of age specific information about new out-patients and the location of a clinic is highly relevant. New contacts in West Lothian were 1.32 per 100 population (Scottish average 0.74). When these were further broken down by age 15–65 and 65+, new contacts for the index service were 1.30 and 2.34 respectively. McKechnie (1985) had already demonstrated that the rise in new psychiatric out-patients could be attributed to the development of out-patient facilities based in health centres.

Medical audit requires that the process should be relevant, objective, quantified, repeatable and able to effect appropriate change in the organisation of service and clinical practice Shaw & Costain (1989). Simple classification if adopted nationally would make medical and, eventually, clinical audit attainable. Without such simple steps attention cannot be paid to resource management, audit, and especially, quality assurance.

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Standards of care revisited – medical audit in practice

DEAR SIRS

The clinicians in the North Audit Group for Mental Handicap Psychiatry in the South West Region have

been actively engaged in medical audit for one year. Brief introductions to some of the principles and ideas that we have employed were presented by Johnston at the Section for Psychiatry of Mental Handicap meeting in March 1990 and published in September 1990. I write now to encourage further those not already actively engaged in medical audit that this can be a very worthwhile process. One year since monitoring the number of anticonvulsant medications prescribed to the in-patient population, this situation has been reviewed. Across all the districts in our group, not just those reported in the previous paper, a reduction in the number of anticonvulsants received by patients occurred. Some patients have successfully had all anticonvulsant medication withdrawn. Further, anticonvulsant medication which was thought to be inappropriate or outmoded has been converted to more acceptable medication. This has not, however, been performed at the expense of seizure control.

The simple procedure of counting and recording the anticonvulsants prescribed, followed by rationalisation of the prescription of such anticonvulsants has, overall, produced a reduction in the total number of anticonvulsants prescribed, the combinations of anticonvulsants prescribed, and an updating of such therapy.

This was the first step in our medical audit of those patients receiving anticonvulsant therapy for epilepsy. This year we have further extended the audit process to include all patients on anticonvulsants and have set up and designed standards which we consider to be minimal in the monitoring of anticonvulsant medication.

We have recognised and highlighted that the next stage may well be the monitoring of seizure control, this being an inexact and unreliable situation at present.

It is only when we can draw together the results of the various small audit exercises that we will be able to say with any degree of certainty that the patients receiving anticonvulsant medication for whom we provide the clinical care receive what we consider to be the most appropriate anticonvulsants and that these are monitored adequately for the benefit of the patient.

Collecting data for medical audit is undoubtedly a time-consuming task. The presentation of audit data is difficult. However, the retrieval of last year's data for comparison makes the previous difficulties seem minor inconveniences. Our experience has highlighted the need for simple medical audit, the data for which can be relatively easily collected and tabulated, and centrally stored safely so that additional aspects of the clinical problem which may be similarly audited in a small way can be built on subsequently.

Since our audit exercise we have been able to write clear operational guidelines which we hope will be applied not only within our hospital settings, thereby maintaining what we consider to be good standards of care, but also which could be applied to populations of people in the community.

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Out-patient follow-up clinics

DEAR SIRS

In reply to Drs Davidson & Pooles' letter (*Psychiatric Bulletin*, June 1990, **14**, 371–372), our study may be adequate enough to describe the workload of a registrar follow-up clinic, but is not necessarily representative of other clinics held in the hospital studied. The thrust of our paper was that this is a widely used resource where little is known of the characteristics of attenders and non-attenders.

Davidson & Poole are surprised that we do not emphasise that 89% of patients suffered from schizophrenia or manic-depressive illness. However, in inner-city catchment areas patients with a diagnosis of schizophrenia are known to be over-represented by social drift. Both diagnostic groups have chronic, relapsing illness and will by self-selection inevitably be further over-represented in clinics.

This is a vulnerable group and while there are limitations to such clinics, this does not mean that an inadequate standard of care is offered or that Davidson & Pooles' suggestions will improve matters. Their statement that "maximum continuity of care and expert input cannot be found in a registrar clinic . . ." is a sweeping generalisation without any supporting data. This surely depends on the caseload of the catchment area, type of patients seen, expertise of the registrars and the amount of supervision given by senior staff to registrars. We cannot comment on the present organisation of clinics in Liverpool, but in the district studied all patients who were particularly difficult to manage or vulnerable were usually seen by the consultant and senior registrar, supervision was readily available, and at times of change-over the more difficult patients could be added to the senior lists. Non-attenders were followed-up wherever possible by a number of means including CPN, social worker and domiciliary visit.

Davidson & Poole do not state who are "trained members of the permanent staff" (we take this to mean consultants) nor whether they feel some or all of the 89% identified should be cared for by such