KING's FUND CENTRE

AUDIT AND DEVELOPMENT IN PRIMARY CARE

Charlotte Humphrey and Jane Hughes

DICAL AUDIT SERIES 5

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Charlotte Humphrey
Jane Hughes

PREFACE

This second book on medical audit in primary care by Charlotte Humphrey and Jane Hughes is well timed. Medical Audit Advisory Groups (MAAGs) are over a year old and should by now have presented reports on their first year's activity to their FHSAs. As public service funding comes under threat from a worsening economic situation and as some FHSAs begin to lose money under new capitation funding arrangements, some general managers are questioning the return on investment in medical audit.

While many of them encouraged the profession to take the lead in establishing audit, it was inevitable that as MAAGs moved into their second year, they and their FHSAs would need to conduct their own audit of the system whose aim was to enable every GP to participate by April 1992. This book will both inform and guide these discussions, for it conveys with the help of lively and succinct examples some of the barriers to that participation, together with the mechanisms that can be used to overcome them.

Although they emerge optimistic from their study, our authors acknowledge that not all practices are as yet involved. They also suggest that the necessary link between audit and service development is weak, due to poor dissemination of audit findings and experience both within and across practices. They urge us to rethink audit, viewing it as a means rather than an end. The aim is not to have every GP or practice 'doing it', but to have them using it as a tool with which to tackle problems they have themselves identified and to improve patient care. To do this each practice needs to ask what it wants to achieve and how audit can help it do that. FHSAs and MAAGs need to pose similar questions for themselves.

By the time this book is published, we shall have a Patients' Charter for primary care. Its introduction in the context of an independent contractor-led service will require considerable skill. Many of the lessons drawn so lucidly here will be relevant to that task.

June Huntington
October 1992

EXECUTIVE SUMMARY

This book explores how audit can be used productively in primary health care. Drawing on the experience of people who have been involved in organising audit, it investigates how medical audit advisory groups (MAAGs) can help all practitioners to take part in regular and systematic audit. It illustrates and analyses the opportunities for using audit across the spectrum of development, from solving modest individual problems to implementing and evaluating service-wide changes in care. At all levels audit can make a valuable contribution, but using audit to stimulate and fuel development is certainly not yet commonplace. *Audit and Development in Primary Care* concludes with a positive assessment of the future for audit in primary care. However, it warns that the impact of audit may remain patchy and parochial unless changes are made to the way it is carried out and to the organisational structures which support it.

Audit as innovation

The emphasis of government policy is on getting all general practices involved in doing audit of some sort. MAAGs carry the main responsibility for getting audit off the ground and many GPs, primary health care teams and service managers are currently exploring what audit can offer. Looking at audit as a health care innovation, this book illuminates the obstacles to introducing it and suggests how they might be overcome. Practical examples are given which show how to ensure that audit is seen as relevant, acceptable and desirable in principle; how to make it practicable and worthwhile in practice; and how to improve the chances of carrying it through to a successful conclusion. Some MAAGs are already using the tactics that are described, and are well on the way to engaging the majority of practices in audit.

Audit and Development in Primary Care argues that the time has now come for a longer view, in which audit is seen not as an end in itself, but rather as a means to an end – part of the wider process of improving the quality of care. The pertinent questions to ask are 'what do we want to achieve?' and 'how can audit help?' The book goes on to explore the relationship between audit and a range of development objectives in primary care.

Audit and development

Practical examples are used to illustrate how audit can contribute to development at three levels in primary care: individual professional development; development of the services provided by a practice or health clinic; and development of services for a population. In some cases, audit also provides a link between developments at different levels. However, many of the examples are unique. They exist because an enterprising individual saw the development potential of audit and took the initiative to follow it through. They have not been replicated in other places or translated from one service to another. The book concludes that the potential role of audit in primary care development is substantial, but it is not yet fully realised.

Recommendations for change

A number of changes in the way audit is carried out are suggested which should increase its impact on the quality of primary care. These include the following:

- establishing routines which integrate audit into the work of individual practitioners and primary health care teams and embed it into management of services. Systematic and planned use of audit, based on a model of continuous improvement of practice, is less wasteful and more effective than an *ad hoc* 'hit and run' approach;

- encouraging multidisciplinary and collaborative audit. Across all sectors, stronger links need to be forged between those who share similar development aims, Patients, too, must become more equal partners in audit. Change is more likely to be successful if all those with a stake in a development are involved from the start;

- making better connections between grassroots audit activities and planning and policymaking at authority level. Establishing vertical links helps ensure that audit is seen as relevant by all stakeholders and that audit findings are used appropriately;

- collating more systematic and accessible information about primary care audit. Sharing information more freely would raise awareness of the possibilities and pitfalls and avoid duplication of effort;

- providing more help with audit and development initiatives. Facilitators and brokers of all kinds can help disseminate information and increase collaboration, especially across professional and organisational boundaries. Organised audit schemes with built in brokerage offer the best change of achieving change.

MAAGs should play a central part in making these changes and, in turn, their own roles and relationships need to be reviewed. It is suggested that:

- the remit of MAAGs should be enlarged to encompass broader development objectives;

- links between MAAGs and the development functions of FHSAs and other agencies should be reinforced;

- MAAG membership should be altered to reflect the whole constituency of interests in primary care.

In this way MAAGs, or their successors, will be able to build on their achievements and increase their influence on primary care development.

The book ends on an optimistic note, looking towards the future for audit as an integral part of the wider movement concerned with quality and accountability in health care. This movement is evolving fast, and organisational developments in the health service are assisting its momentum. Given the current pace of change, the audit initiative in primary care is unlikely to continue exactly as presently conceived, but the principles and opportunities it represents should be here to stay.

INTRODUCTION

The 1989 White Paper *Working for Patients* stated that all doctors should undertake regular, systematic audit of their practice.[1] In primary care, family practitioner committees (now family health services authorities) were required to set up medical audit advisory groups (MAAGs) to develop and coordinate audit activities in their areas. Medical audit was hailed as a future cornerstone of quality assurance in primary care.

Given that substantial organisation and resources are being invested in its development, audit in primary care needs to be made as effective as possible in enhancing performance and improving service quality. The first task of MAAGs and others responsible for promoting audit is simply to get as many people as possible involved in doing audit. The second, however, is to ensure that what is done in the name of audit is truly worthwhile. Ways of linking general practice audit with other quality assurance activities must also be identified and strengthened so that medical audit both complements and contributes to the overall development of primary care services.

Our purpose in this book is to identify some practical strategies for getting audit established effectively in primary care and to explore the substantial opportunities it offers for improving service quality. The book is thus intended to be of interest and practical value not only to those with a specific interest in promoting medical audit, such as MAAGs, family health services authorities (FHSAs) and health authorities, but also to people with a wider interest in the development of primary care services.

The book is based on information and ideas obtained from a variety of people working in primary care who have had experience of organising audit over the past few years. We do not seek to provide a comprehensive survey of current practice – the situation is now changing far too rapidly for that to be appropriate. Instead we have chosen case studies and practical examples for their value in demonstrating the opportunities and also sometimes the difficulties to be encountered in this area.

The case studies we describe and the examples we discuss have been identified by several different routes. The experience of preparing a major review of the UK literature on audit in general practice for the King's Fund Centre gave us a fair idea of what had been going on as far as published examples of audit are concerned.[2] Since then we have done our best to keep up to date with the rapidly expanding audit literature and a number of our examples are drawn directly from material published recently in mainstream journals, notably the British Medical Journal. Other interesting audit projects were identified through discussions with the Royal College of General Practitioners (RCGP), academic departments of primary care, the King's Fund Centre and FHSA and health authority staff in several districts. Attendance at conferences and participation in a number of training workshops on audit around the country gave us a third source of leads to follow up. Between September 1990 and February 1991 we carried out 30 interviews with people involved in audit in primary care from a variety of perspectives including GPs, members of the original pilot MAAGs, consumer organisations, researchers and health service managers. In many cases we have maintained contact since the initial interview in order to keep up to date with more recent developments.

Our premise in writing this book is that audit is an important and worthwhile innovation in its own right. More than this, though, it is a valuable starting point for the pursuit of quality and service development in primary care. The present focus of audit in general practice is predominantly on educational and professional development within individual practices. In some parts of general practice – notably through the RCGP Quality Initiative – audit has been

used as a means of pursuing such objectives for some time.[3] However, for many GPs, the new spotlight on audit is currently providing the impetus to explore what audit offers for the first time. Thus we are going through a necessary learning period during which people working in primary care are becoming more familiar with the uses of audit, its methods and the resources it requires. The main objective in the short term is to reach a position where the majority are able to make informed and sensible choices about when and how to use audit effectively.

However, once such skills and understandings have been developed, there is much to be said for encouraging a shift in emphasis towards a longer view where audit in itself ceases to be the major focus of attention. Rather than asking 'what is audit? what can we do with it?' the pertinent questions become 'what do we want to achieve? how can we get there? can we use audit to help us do so?' Development objectives for people working in primary care encompass individual personal ambitions and the improved functioning of their immediate practices. They may also include the development of wider services which bridge a variety of professional and organisational boundaries. Audit has a role to play at all these levels and we have identified a range of examples which demonstrate the contribution it can make.

This book is structured to reflect the progression proposed above. In Chapter 1 we look at people's experience of promoting audit as an innovation – a new conceptual framework for investigating, defining and assessing practice with a range of specific techniques and applications. Much has been learned about getting started on audit, several valuable strategies can be identified and these are discussed and illustrated. In the next three chapters we then look at how audit can feed into development at different levels in primary care. Chapter 2 is concerned with personal and professional development, Chapter 3 with practice development and Chapter 4 with the development of services on a wider scale. Practical examples are used to demonstrate the variety of opportunities for audit that are already being explored. In the final chapter we draw together some conclusions and recommendations about the role of audit, now and in the future, for those in the MAAGs and elsewhere who are directly concerned with its use and also for people with a broader interest in improving services and enhancing quality in primary care.

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CHAPTER 1
AUDIT AS INNOVATION

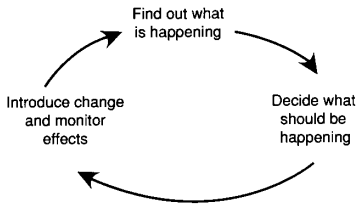
An innovation is an idea, practice, or object that is perceived as new by an individual or other unit of adoption. It matters little, so far as human behaviour is concerned, whether or not an idea is "objectively" new as measured by the lapse of time since its first use of discovery. The perceived newness of the idea for the individual determines his or her reaction to it. If the idea seems new, it is an innovation.[1]

In this chapter we discuss the promotion of audit as an innovation in medical care. We begin by outlining the concept of audit and the proposals for audit in the 1989 White Paper *Working for patients*.[2] Next we explore attitudes to audit in primary care and discuss the opportunities for encouraging people to get involved. We describe a variety of strategies that may be useful at this initial stage. At the end of the chapter we begin to look beyond promoting audit as an end in itself and consider how it can help to achieve development and change at many different levels in primary care.

The concept and the context

Audit is a methodological tool. To those involved in providing care, audit offers a systematic framework for investigating and assessing their work, and for introducing and monitoring improvements. Audit is conceived of as a cyclical activity, on the assumption that reviews of this sort should be carried out continuously. This 'audit cycle' is shown below.

Figure 1.1. The audit cycle



Informal review and evaluation of practice with a view to improving patient care is of course an established part of the clinical tradition in all areas of medicine. In primary care, some GPs have been engaged in extensive formal investigations of their own work for a number of years [3,4] and all GPs carry out some informal reviews of their practice activities (such as looking for ways to improve their appointments systems), if only to keep things running tolerably smoothly. What is new, however, is the use of the term 'audit' to describe this area of work, the extensive exploration and development of its methods and its uses, and its adoption as a central plank of policy for medical practice.

Medical audit was introduced in the 1989 White Paper as a 'fundamental principle of the review'.[2] Although the antecedents of audit in primary care were acknowledged in the White Paper by reference to such activities as the RCGP Quality Initiative, it was essentially presented as a major new idea. Audit was defined as 'the systematic process by which doctors continually assess and evaluate their clinical practice, the organisation of services, their managerial function and educational activities'. It was expected to provide doctors and managers with information 'to enable improvements to be made in services to patients, to plan ahead and to improve quality. It enables efficient and effective use to be made of resources.'[2]

Policy documents stressed that audit should remain in the hands of the medical profession and emphasised its links with education and professional development, but links to management were also to be secured by establishing advisory groups in each district health authority (DHA) and FHSA to plan and monitor medical audit programmes. In primary care, each FHSA was to set up a medical audit advisory group (MAAG) that would be accountable for the institution of 'regular and

systematic medical audit in which all practitioners take part'.[5] The aim was for all practices to be engaged in audit by April 1992. In the White Paper it was suggested that participation in medical audit should in future become a contractual obligation for all GPs.[2]

Attitudes to audit

When *Working for Patients* was published, the proposals for audit gained more widespread support than any other component of the NHS reforms. In contrast to most of the other suggested changes, audit was widely acknowledged as an idea whose time had come. In primary care, while some doubts about audit certainly existed among GPs on the ground, those who spoke for their speciality were united with other commentators in voicing their approval.[6,7] The prospects seemed good for the widespread adoption of audit in primary care.

However, a basic lesson from studies of the diffusion of new ideas is that even straightforward innovations providing simple solutions to important problems are not necessarily taken up with any speed.[1] If this is the case, audit is going to need all the help it can get to become established successfully, for it starts with several built in disadvantages. Audit is not a straightforward concept to grasp, it is not necessarily simple to undertake and its benefits may not be immediately obvious. In the short term it can sometimes throw up more problems than it solves. In the circumstances of present day primary care, where practitioners are faced with a variety of competing pressures and demands on their limited time and resources, audit may seem neither an urgent nor a particularly attractive option at first sight.

The chances of getting audit quickly and effectively established in primary care will be optimised by acknowledging these practical and perceptual problems and by systematically identifying ways of dealing with them. In the discussion that follows we have adopted this approach, summarising the possible sources of difficulty under the three categories shown in Figure 1.2: problems of perception, motivation, and implementation. Having identified the potential barriers to audit in each of these areas, we define the tasks to be addressed and discuss a variety of strategies for dealing with them. These are illustrated by examples.

Figure 1.2. Potential barriers to audit in primary care

Problems of **perception**:
- ❑ uncertainty about what audit is
- ❑ scepticism about its relevance
- ❑ anxiety about what audit may reveal
- ❑ resentment about where it comes from

Problems of **motivation**:
- ❑ doubts about the value of audit to the practice
- ❑ concern about resource implications and opportunity costs
- ❑ other more pressing priorities

Problems of **implementation**:
- ❑ structural or communication difficulties in the practice

The ideas and approaches we discuss here were identified through talking to GPs and others who have taken the lead in promoting general practice audit (including those involved in the early pilot MAAGs) and are based on their experiences. We are not concerned with individual practitioners' methods of getting audit going within their own practices. Our aim rather is to identify effective strategies for use by FHSAs, MAAGs, local medical committees (LMCs), academic departments and others involved in post-graduate medical education who are faced with the task of getting people involved in audit. Our assumption is that links between these agencies and those working in primary care will involve some combination of direct personal contact (through meetings, visits, facilitators, courses or seminars), indirect contact (via newsletters and information networks) and, in some cases, research programmes.

Problems of perception

Perceptual barriers to audit reflect problems of understanding and cultural and political attitudes. The tasks for those who seek to overcome these barriers are to:

- ❑ **emphasise the continuity** between audit and the many review and evaluation activities already going on in primary care;
- ❑ **acknowledge the variety** of activities which may legitimately be described as audit;
- ❑ **minimise the threat** of external scrutiny;
- ❑ ensure that **ownership** of audit lies with those most immediately involved.

Emphasising continuity

The most effective way to introduce audit may be not to discuss it at all in the first place, but rather to start by getting people to reflect upon their own work. Get them to think of ways in which they are already involved in monitoring and modifying what they do. Encourage them to consider what information they already collect and how they use it and to identify further areas of their practice which they would like to know or do something more about. This can all be done without reference to the terminology of audit, and has the advantage of circumventing prior assumptions about what audit involves. For those who are anxious about not having the knowledge, skills or resources to embark on audit, such an exercise is valuable because it tends to demonstrate to almost everyone that they have already been doing audit informally without knowing it (see example 1.1, *Identifying audit in the practice).*

Subsequently, the relationship between participants' activities and concerns and the more formal methodologies of audit can be explored. New techniques or frameworks may then be adopted to capitalise on existing procedures and to build on areas of interest, using a model of development rather than imposition or subversion. Through ensuring that discussion is firmly grounded in the realities of people's own experience, their circumstances and their self-defined needs, such an approach to audit both assists in its demystification and diminishes the likelihood of charges of irrelevance.

Acknowledging variety

The quality of any audit activity should be judged, not by the elegance of its methodology or its impressive presentation, but by its real value to practice or patients. Though completing the audit cycle may be desirable, the value of audit does not depend entirely on doing so. Luckily so, since the majority of practices will rarely succeed in completing the cycle in most aspects of their work. Even the most basic activities relevant to audit – such as sorting out systems of record-keeping – can be valuable in their own right. There are also many spin-off benefits for the practice team which may come out of the process of doing audit. For example, defining common objectives and protocols has been found to provide a sense of direction and a useful focus for understanding the roles of different team members, as well as offering a potential basis for individual staff appraisal (see *A primary health care team manifesto,* example 3.5, page 47).[8]

No single approach to audit can claim a monopoly of value, because none is applicable to every aspect of a practice's work. Again this is fortunate, since no one method will suit everyone's inclinations or circumstances. It is therefore necessary to offer examples of simple and complex audits, qualitative as well as quantitative methods, collaborative and individual approaches. Also, if any external evaluation is intended, it is important to acknowledge explicitly that all these approaches are equally valid: this then rejects the unspoken hierarchy which tends, reflecting similar biases in research, to place large-scale, generalisable, quantitative studies at the top of the pile.

1.1 Identifying audit in the practice

At a day on audit for GPs, practice managers and practice nurses, participants were asked to reflect on the ways in which they had reviewed or modified their practice during the previous year. One of the participants, whose initial assumption was that she had no experience of anything that might be called audit, came up with the four examples given here.

- The practice manager had carried out a review of the activities of the diabetic clinic which confirmed the high quality of work being done and the lengthy time given to each patient. She summarised the findings and presented the case to the FHSA that payments should be made for a clinic of five patients rather than ten. The FHSA agreed and the income from the clinic was thereby doubled.

- The partners in the practice had met to review their referral decisions. During discussion it emerged that one of the GPs was quite willing and competent to undertake a minor surgical procedure for which his partners had been referring patients to hospital. It was agreed that in future all such patients would be referred directly to him.

- The practice nurses had complained that they were wasting time on inappropriate administrative tasks. It was agreed that they would monitor their work to see what could be done about this. They used a stop watch to measure the interruptions occurring during one morning clinic. During a two hour period they recorded 11 telephone calls and six other interruptions. Their initial response was to suggest that all the telephone calls should have been intercepted by the receptionists. However, on reflection they acknowledged that most of the telephone conversations included giving advice which they felt could only be given by a nurse. The remaining calls were to book appointments with the nurse. Subsequently it was agreed to make it known to patients that there would be a fixed time each day when a nurse would be available to give advice over the telephone, thereby avoiding interruptions during the clinic. The receptionists took on the responsibility of booking appointments for the clinic nurses' treatment room sessions.

- The receptionists had been taking large numbers of telephone messages for the health visitors and district nurses, and this was interrupting their work. Using a duplicate message book, they counted the messages recorded during one week's work. Fifty such messages had been taken. They used this information to back up their request for an answering machine for the district nurses and health visitors. This was subsequently provided, to the satisfaction of all concerned.

The obvious hazard of such an eclectic approach is that it may produce a situation where anything and everything passes for audit and the quality varies hugely. But quality will be variable in any case. It seems reasonable to suggest that a definition of quality which uses the criterion of value to participants or patients is a more justifiable and less arbitrary measure than some more abstract yardstick of conformity to standards of good audit which can realistically be achieved by only a minority of practices. The Liverpool MAAG agreed to define audit as 'any systematic analysis of what we do... particularly if such audit seems to result in improved patient care'.[9] The advantage of such a broad-based approach to audit over one which is more concerned with methodological rigour is that it seems likely to engage a greater proportion of people in doing something which may be useful to them, while not preventing those so inclined from doing more thorough and formal audits.

Minimising threat

The perceived dangers of participating in audit act at two levels. The first, and better aired, derives from fears about being judged and found wanting by some external agency. Whether participation in audit will eventually become a contractual obligation for GPs remains unclear, but at the least it seems likely to become an informal measure of competence. In these circumstances, there is a possibility that in the future MAAGs will be asked to develop some kind of accreditation role.[10] That prospect is deeply disturbing to many GPs and accounts for some scepticism about the commitment to absolute confidentiality that many MAAGs and FHSAs are presently emphasising.

While the future remains unclear, the most robust protection for those participating in audit may be to ensure, as the Liverpool MAAG has done, that individuals and practices are able to make their own decisions about what information from their audits will be available to whom (see example 1.2, *Confidentiality measures adopted by the Liverpool MAAG).*

The disadvantage, from the MAAG's point of view, is that this may limit its own opportunities to assess whether it is fulfilling its role effectively and to demonstrate this to the FHSA and beyond. However, there are ways of getting round this difficulty. The Oxfordshire MAAG's audit of practice audits offers one ingenious solution (see example 1.3).

1.2 Confidentiality measures adopted by the Liverpool MAAG

MAAG meetings are held in two parts, the second part being closed and available for the discussion of sensitive, personalised, confidential information about practices. This part of the meeting is attended by the MAAG's professional members and the audit facilitators only.

The practices themselves decide on the level of disclosure of information collected by the audit facilitators. Three options are available.

They may decide to divulge the information to:

- ❑ the facilitator only;
- ❑ the MAAG;
- ❑ the FHSA.

Although located within the FHSA building, the MAAG office operates as a discrete entity with its own direct telephone line and post office box number. Only the administrative assistant and the facilitators have access to data stored on the computer.[9]

1.3 Oxfordshire MAAG's audit of practice audits

The MAAG set out to develop a systematic method for audit of practice audits which would provide both a summative assessment of audit in the Oxfordshire area and a formative assessment for individual practices of the completeness of their own audits.[11]

A coding system was devised which enabled audits reported to medical audit advisory coordinators on practice visits to be assessed according to the degree to which they completed the various stages of the audit cycle. Different levels of audit were then classified as full audit, partial audit, potential audit, planning audit or no audit.

Data collected by MAAG audit coordinators about individual practice audits were coded and classified at two levels. First, audits were analysed for each practice so that the practice team could see which of their audits included the various stages of the audit cycle. Second, the audits of all Oxfordshire practices visited were analysed to give a measure of audit activity in the county.

Subsequently, the MAAG has used the criteria it developed for assessing the completeness of audits to set target standards for its own activity in the future and to encourage practices to improve the quality of their audits.

Relationships between the statutory agencies and local practitioners obviously vary substantially between districts, and are influenced by mutual history well beyond anything to do with audit. One immediate factor in the equation, however, will be local perceptions of the integrity and allegiances of the MAAG members. In considering the make-up of the group, MAAGs and FHSAs clearly have to consider what is the appropriate balance between local opinion leaders, innovators, change agents, experts, enthusiasts and 'representative' or 'ordinary' GPs. These may be the same people, but studies of innovations in other areas indicate that frequently they are not.[1,12] The examples that follow (1.4 and 1.5) describe some of the Newcastle MAAG's deliberations regarding membership and the procedure for the initial selection of members on the Liverpool MAAG.

At another level, both anxieties about the dangers of audit and efforts to provide safeguards reflect two fundamental assumptions. First, that the function of audit is to reveal and remedy faults in performance. Second, that such faults will indeed be found (see example 1.6, *Audit as a threat to self esteem*). The first assumption reflects a particular punitive attitude rather than anything inherent in the activity of audit. A more constructive approach to audit is one that explicitly eschews blame, seeking rather to identify opportunities for improvement.[15,16,17] If the latter approach is convincingly championed, then fears of retribution should be diminished.

The assumption that faults will be found may still be true. However, the identification of weaknesses may equally be tempered by confirmation through audit that some things are being done well. One option to encourage people to do audit is deliberately to play to their strengths, choosing aspects of practice where most will be reassured by their findings. Having built up confidence and experience in this way, people may then feel emboldened to tackle more difficult aspects of their work.

1.5 Selection of the Liverpool MAAG

A specific number of nominees was sought from the various bodies representing the profession with a request that nominees who were working GPs with an interest in audit be put forward. The outcome of this process was a MAAG constituted as follows:

- four representatives from the LMC;
- one representative from the university department of general practice;
- one hospital consultant;
- two representatives from the RCGP;
- one representative from the teachers of postgraduate general practice;
- one representative from the FHSA.

The process 'allowed the profession to "vet" itself and ensured that both the official bodies and working GPs were represented in a way which the FHSA and the profession found acceptable'.

However, it was noted that all the GPs nominated by this process were male, relatively young and white. They all worked in group practices and had been vocationally trained. The MAAG members decided against positive action to ensure that other groups were represented, but agreed to bring the situation to the attention of the nominating bodies when the membership of the MAAG next changed.[9]

1.4 Views on membership of the Newcastle MAAG

The question of whether GP members of the MAAG should be representative of, or should represent, local GPs was debated at several of the early meetings of the Newcastle MAAG. It was concluded that 'the MAAG is different from the LMC, and has a different purpose. It does not represent GPs in any political sense (though this may change if audits reveal resource needs). However, the MAAG needs to be credible with local GPs in general and the LMC in particular. An antagonistic LMC could easily undermine its work and hinder progress. The MAAG does need to be representative of local GPs. This will ensure that it has available GPs with particular experience and expertise, for example women doctors, single-handed doctors and doctors from ethnic minorities'.[13]

1.6 Audit as a threat to self-esteem

In an article entitled *How does audit make you feel?*,[14] Richards discusses how audit may pose a threat to the mechanisms and thought processes which GPs use at times of stress or uncertainty to maintain their confidence and self-esteem. He includes the following examples:

'I always try to do my best.' (Audit might show I could do better.)

'I'm better than my partners at dealing with this condition. I wish they would adopt my methods.' (What if it's the other way round?)

'This is how my old teacher always did this..... He would be pleased to see me follow in his footsteps.' (Audit criteria and standards might show that we're both out of date.)

Alternatively, the risks may be avoided altogether by auditing problems known to derive from outside the practice, for example looking at delays in the receipt of referral letters from hospital. There is of course little point in encouraging practices to embark on such investigations unless there is some prospect of acting upon the findings. In these circumstances, MAAGs and others need to be prepared to act as brokers, picking up such issues and following them up with the external agencies concerned.[10]

Ensuring local ownership

Anxiety about external scrutiny may be compounded by resentment about external imposition of the requirement to do audit. Moreover, the policy on audit may be seen as just one more example of general interference by Government in areas of clinical work. If ideas and strategies for audit are also seen to be imposed from outside this simply adds to the provocation. Quite apart from such concerns, there is evidence that innovations that are locally owned and adapted or 'reinvented' to suit local circumstances are more likely to be successfully taken up. Within general practice, it has repeatedly been found that individuals who participate actively in the development of audit or evaluation procedures are more likely than their less involved partners to act upon their results.[4,18]

Local ownership may be facilitated by working as far as possible with existing local groups and networks, encouraging them to see where audit might fit into their own agendas, rather than expecting the agendas to change to accommodate audit. Locally generated ideas for audit might then include politically or emotionally 'hot' topics relating, for example, to controversial aspects of the NHS reforms or the GP contract.

The adoption of this sort of 'bottom up' approach to audit does not necessarily involve ceding all initiative to the grassroots. It has been shown that direct access to local role models and contact between near peers – those who are most similar to one another in attitudes, experiences and circumstances – is the most effective way of spreading the uptake of new ideas.[1,19] MAAGs and others can stimulate this process by supplying information, feeding in ideas, identifying local examples, stimulating discussion, offering technical support, providing literature searches and other resources, encouraging contact between practices and developing other communication channels such as newsletters and databases to help disseminate ideas and share experiences (see descriptions of the Liverpool MAAG audit database and the Newcastle *Maagazine* in examples 1.7 and 1.8). Through such a process of 'sneaky leadership', groups and individuals may be encouraged towards audit, perhaps even towards audit of particular topics but, importantly, the choice as to what they do and how they do it remains in their own hands.

Problems of motivation

Once the perceptual barriers have been overcome, audit may well be acknowledged as relevant, acceptable and, in principle, desirable. However, there remains a substantial gap between regarding something as worthwhile in theory and getting round to doing it in practice. Coercion aside, whether or not any practice or individual becomes sufficiently motivated to start doing audit themselves will be determined by their view of the likely costs and benefits of audit, whether they have the necessary resources to do it and how they regard its importance against other competing priorities. The tasks for those seeking to tip the balance in favour of audit are therefore to **maximise the benefits** and **minimise the costs.**

Maximising benefits

As we said earlier, there are benefits to be gained from the process of doing audit besides those which derive from the results of the audit itself. Benefits of both kinds will influence motivation. It seems reasonable to suggest that, to most people, benefits that are real and tangible will count for more than the abstract assets often attributed to audit by those who promote it, such as its role in enabling people to think critically.

1.7 The Liverpool MAAG audit database

The MAAG database is a collection of information on local audit activity and projects, audit protocols and articles from journals, the GP press and other audit publications. Information on local audit activity is collected from facilitators' visits or volunteered by practices. Practices are encouraged to feed back into the database from their own experience and to share the local anomalies they encounter. Various publications are scanned regularly and references followed up. The database is constantly expanding and uptake is monitored. Details of the areas covered on the database are circulated via the quarterly MAAG newsletter.[9]

1.8 The Newcastle Maagazine

The Newcastle MAAG newsletter, the *Maagazine,* is published quarterly with the aim of providing a forum for ideas and news about medical audit locally. It contains numerous items of information about the MAAG, its membership, its activities and the resources it can offer. Presented in a lively and informal style, it enthusiastically invites participation, comments, criticism and contributions from anyone in local primary care. In the first year of publication, the *Maagazine* included items on the venues and activities of local audit groups and several reports of audits carried out by Newcastle general practices.

What, then, are the real benefits to be had from engaging in the process? First, incentives can be offered. One of the most obvious ways to do so for GPs is to negotiate post graduate education allowance (PGEA) accreditation for courses involving audit (see the discussion of PGEA in Chapter 2). An advantage of PGEA is that it is likely to pull in GPs from right across the board, irrespective of their basic interest in audit. The disadvantage is that a one-off course may induce very little lasting interest in audit. Another way of encouraging participation is to make the process itself enjoyable, for example, through facilitating group work which also offers social support and relaxation or simply by providing good lunches at audit meetings. The Newcastle MAAG chose to set a positive tone for audit activities from the outset, by providing each of its members with a red carnation button-hole to wear at its first open day!

None of these encouragements will count for much, however, unless there are also real advantages to be gained from the audit itself. For those who are not fundamentally committed to audit for its own sake, or who need to persuade others in their practices to participate, the benefits need to be fairly obvious and realisable in the short term. For others, the possibility of more abstract or longer term advantages may be sufficient. Audits leading to benefits in kind include those which provide practices with the data to negotiate for new resources, those which enable more efficient use of existing resources, and those which help practices to reach national targets or obtain more fees. Audits leading to improvements in working conditions include those which help to achieve better relationships with staff or patients, a more efficient use of time or a reduction in stress. Audits which may enhance intellectual or professional satisfaction include those which extend knowledge or skills, result in better clinical care or lead to publications or career advancement.

Published examples of how audit can benefit the practice are now numerous, and the literature is growing fast.[10,20] But the promise of benefits from audit will be far more compelling if local examples of their achievement can be demonstrated. Every opportunity needs to be taken, therefore, to encourage those who have done successful audits to make their successes visible to others. Many MAAGs have begun by getting their own members to undertake audits which are then presented and discussed as examples at open meetings. Several have proposed introducing cash prizes to encourage presentations from non-MAAG practices.

Minimising costs

However desirable the benefits may be, audit will not be undertaken unless the effort required is felt to be both reasonable and manageable. One generally recommended strategy is to delegate tasks to practice staff wherever possible (see example 1.9, *Audit in general practice by a receptionist).*

Costs to the practice may also be diminished by providing external help with any part of the audit itself, in terms of manpower, expertise, finance or computing support for example. In Lincolnshire, the general manager of the FHSA allocated £50,000 from general medical services funds to be administered by the MAAG in order to reimburse practices for expenditure on extra staff time spent on audit activity in 1991-2. Practices have applied for this funding either as reimbursement for overtime for permanent staff or for temporary staff employed for a specific project. The majority of practices have taken the former option. Reimbursement has been claimed for all types of staff, including practice managers, practice nurses, practice secretaries and receptionists.[22]

In Liverpool, medical students from the University are regularly involved in helping practices to initiate audit projects. The students are available for one week at a time, with three and a half days spent at the practice. The FHSA awards a prize for the best audit project presented. Practices report that the students' arrival has accelerated the starting of projects, and the great majority that have had students have asked for them again.[9] Liverpool GPs are

also able to bid for a one month placement of a regional trainee to undertake medical audit projects in their practice.

Alternatively, the Rent-an-Audit scheme developed in Oxford provides a service in which an entire audit is carried out over the weekend by a visiting team.[23] Tried and tested off-the-shelf audit packages have also been produced.

In the extreme case, one disadvantage of providing such support could be that practices which are relieved of responsibility for the audit also lose their sense of ownership and this may diminish their commitment to the undertaking. An alternative is to provide locum support in other areas of work, thereby releasing resources to put into the audit, for example by giving someone the time to read up on a topic they are investigating (see example 1.10, *The Cambridge Guidelines Project).* A more indirect and long-term strategy, producing benefits across the board, is to assist practices in streamlining their day-to-day activities, for example by funding computer facilities. The reduction in overall workload and the simplification of data recall would both enhance the chances of time for audit.

Finally, the costs of audit may be diminished by building it into other activities which are necessary in themselves, such as the production of the annual report (see discussion of development plans and practice annual reports in Chapter 3), the development of a business plan or, for fundholding practices, the specification of contracts.

Problems of implementation

Having understood and accepted the purpose of audit and made the decision to do it, some obstacles to undertaking it successfully may still remain. Few people in primary care work entirely on their own, and few practice audits can be carried out without cooperation. The nature of practice relationships and the views of all those involved will be critical to the outcome of any plans for audit. In some cases, practice-based audit may be difficult or even impossible

1.9 Audit in general practice by a receptionist

In the light of the acknowledged need to delegate the collection of data for audit to practice staff wherever possible, a six-doctor practice set out to examine whether audit could be done cost effectively by a practice receptionist.[21]

The practice set goals for immunisation, follow up of patients with abnormal cervical smears, frequency of recording blood pressure and smoking habits, screening of patients over 75, care of diabetic patients and patients with serious mental illness, antenatal care, variations in workload, and availability of appointments. Forms were devised for the receptionist to collect, analyse, and present data to assess whether these goals had been achieved in the previous year.

The authors of this study report that the receptionist found it quite feasible to carry out these tasks in four hours a week as part of her general duties. After deduction of reimbursements and tax, the cost of this work came to £30 per doctor per year. The receptionist found the work interesting. It gave her new skills and greater insight into the practice's activities. In contrast, the authors express doubts about whether the doctors themselves would have been prepared to devote the 200 hours a year that seemed necessary for this activity.

in the short term. The tasks here, for those who are concerned to ensure that audit can be introduced successfully are to help **prepare the ground** and to identify and facilitate **alternative approaches**.

Preparing the ground

An audit that is well-conceived and well-designed on a technical level, and eminently desirable in the view of its proponents, can still fail because of local circumstances. Straight unwillingness to cooperate is the most obvious difficulty, but there are others which may be more to do with matters of organisation or understanding than actual hostility. For example, poor decision-making procedures within the practice, unsatisfactory arrangements for communicating between team members or lack of agreement about roles may undermine the implementation of an audit plan. At a later stage in the process, failure to take account of the varying views and needs of different stakeholders may lead to conflict about the implementation of changes following audit. For example, changes in the appointments system following an audit of the problems posed to doctors by fitting in extra patients could rationalise the doctors' workload but, unless the implications for staff and patients were also considered, the new arrangements might be unacceptable to others in the practice.

There are techniques for ensuring that such problems are systematically identified at an early stage (see example 1.11, *Managing change in general practice*). Moreover, once the difficulties are recognised and acknowledged, ways of negotiating round the obstacles to any particular audit proposal may well be found. Nevertheless, the importance and general prevalence of such difficulties suggests that a fundamental task of anyone promoting audit must also be to promote more open-ended development work in primary care concerning teamwork and the management of change (see the discussion of the HEA's *Primary Health Care Team Workshops* in Chapter 3).

1.10 The Cambridge Guidelines Project

In Cambridge a project is under way which aims to get all 35 local practices involved in developing standards. The project is funded by East Anglian Regional Health Authority but run from the Clinical School of the University of Cambridge. It was agreed that there should be no formal links with the FHSA, but the project is being carried out with the FHSA's full approval. It is coordinated through a regular newsletter in which the participating practices are encouraged to share their experiences and disseminate their decisions. To set up the project, a local GP has been funded for two sessions a week for two years to run the newsletter and to service the practices. Participants are encouraged to choose for themselves what they will do. Each practice is then provided with a literature review of their chosen topic which gives a limited number of key references. The guideline organiser within each practice also gets funds from the project grant for a locum for two days while they do the research and thinking. There is PGEA accreditation for two or three meetings between the members of the practice to discuss the standards being set.

(The information about this project was provided by Jeremy Webb, Senior Research Associate at the Clinical School of the University of Cambridge.)

Developing alternative approaches

In some situations it may be clear that difficulties within a practice are intractable, for example where a powerful senior partner is determined not to accept audit in the practice. In these circumstances there is a need for other forums to provide audit enthusiasts with the necessary resources and support. Opportunities for collaboration and mutual support between practices may also be particularly important for single-handed practitioners (see example 1.12, *The Liverpool single-handed doctors' group*).

Whatever the situation within individual practices, inter-practice peer groups offer wider opportunities for social support, sharing ideas and the pursuit of common interests. Some groups may be set up specifically for audit (as was *The West End Audit Group*, example 2.3, page 32). Others might have a broader remit to develop skills or confidence in a variety of ways. In many places there are already local support networks and educationally oriented groups set up by various different groups of primary care workers such as practice nurses, primary care facilitators or practice managers which organise regular study days and meetings. Many are now including days on audit in their programmes and some MAAGs are beginning to include such groups in their activities. Where audit is introduced in such arenas, the chances are greater that those members of the primary care team who often end up having to do much of the practical work involved in audit in any case, will become interested and committed to initiating audit on their own account.

1.11 Managing change in general practice

A model for introducing change in general practice, which incorporates the construction of a 'domainal map', has been proposed by Spiegal and colleagues.[24] Their approach might well be used to evaluate the feasibility of a proposed audit.

The map is created by drawing six concentric circles, which are then divided into as many segments as there are stakeholders in the proposed change. Beginning at the centre, the circles are labelled and the details filled in as follows:

circle 1 – description of the proposed change
circle 2 – names of the stakeholders
circle 3 – current involvement of each stakeholder in the situation where the change is proposed
circle 4 – future benefits of the change for each stakeholder
circle 5 – potential costs of the change to each stakeholder
circle 6 – unaware 'wrecking power' of each stakeholder

Following discussions about the proposed change with all those who may be affected by it, a domainal map be used to provide a visual display of each stakeholder's perceptions of what it involves and of the potential costs and benefits to each individual. The map also makes explicit each person's power to obstruct as well as promote the change. This information can be used to estimate the effort which may be needed in negotiating and implementing the proposed change and to decide whether and how to take the next steps. The same map can be used to present the group with information on which to base negotiation. By considering the map, segment by segment, each person's perspective can be shared with the group.

1.12 The Liverpool single-handed doctors' group

Liverpool has 40 single-handed practices. On the first round of MAAG facilitator visits, it was found that only 10 per cent of single-handed practices were already engaged in audit, compared with 29 per cent of all practices. Several of the doctors said they had little opportunity to discuss practice development with other doctors, and would welcome more contact. A GP experienced in group work (a member of the academic department of general practice, and not single-handed) convened a first meeting in June 1990 to explore their needs. Eighteen out of the 40 single-handed GPs attended. Subsequently, meetings have been held on a monthly basis and a programme of meetings is planned for six months ahead. Meetings are convened by a member of the group and held in a medical centre owned by one of the members.

The group was established as a single handed practitioners' group, not as an audit group, and is free to do what it chooses. Topics discussed in the first year included time management, personnel issues, team building and prescribing. Audits of herpes zoster and miscarriages were undertaken, but the group will not necessarily stick with audit.[9]

Audit as a means to what end?

With strategies such as those outlined above, we are optimistic that many people working in primary care will be stimulated and encouraged to begin doing audit. How many have already got involved is not yet clear. Richards cites a recent survey of the audit activities of the 110 general practices in Mid-Glamorgan. Twenty practices replied. Of those, only nine had carried out some form of audit in the preceding year. He also observes that in the Merthyr and Cynon Valley district only two practices out of 18 represented at a seminar on diabetic care had any experience of audit. He concludes that 'committed believers in audit' are in the minority among his colleagues.[14] However, a more formal study carried out by the Oxfordshire MAAG found that three quarters of Oxfordshire practices had done some audit in the past, although only 58 per cent were currently involved in audit projects. The authors suggest that the lower current rates of audit activity might be attributed to the pressure practices are experiencing to complete their data collection for the FHSA.[11] The Lincolnshire MAAG reports that over 90 per cent of practices are already actively engaged in audit or have audit plans in an advanced stage of preparation.[22]

Of course, the situation is changing rapidly. Most MAAGs have been in existence for not much more than a year and some are still not fully in action. The date set for the participation of all practices was April 1992, but it seems that many MAAGs discounted the likelihood of meeting this deadline well before it arrived.[25] Oxfordshire's target to March 1992 was for 50 per cent of practices to be conducting full or partial audit, 25 per cent to be doing what they term 'potential audit' and half of the remainder planning audit. Table 1.1 shows the progress made by Lincolnshire practices in their audit activity during 1991-2. While 39 practices had already completed one or more audits at the time of the first 'audit ambassador' visit, this figure had risen to 55 practices by the end of the year.

At the other end of the scale, anecdotal estimates of the proportion of practices which seem unlikely to get going at all vary between FHSA districts from 10 to 30 per cent. Strategies for what to do about the defaulters also vary, with some MAAGs planning to concentrate their energies on supporting this group, while others seem likely to focus their efforts on those who are more receptive to encouragement about audit.

How much audit?

Even when the majority of GPs have started auditing, a lot of questions will remain unresolved. How much audit should people be doing, how many topics, how many hours per week? Estimates of the time hospital consultants should be spending on audit range from one hour[26] to half a session per week.[27] The Standing Committee on Postgraduate Medical Education (SCOPME) considered Shaw and Costain's[28] estimate of at least half a session each week 'not unreasonable as a guideline but if other existing PME [postgraduate medical education] activities are added together with audit, plus the PME stimulated by and arising from it, a whole session for some individuals looks more likely'.[29]

No equivalent estimates specifically for GPs have been suggested. The fact that much of the work in most general practice audit is delegated to other members of the team means that such estimates would be extremely difficult to reach. Given the evidence that the most effective audits are those which become integrated with and indivisible from other routine activities, designated audit time, except perhaps for planning, is probably an inappropriate objective in any case. An alternative approach is to estimate audit activity on a piecework basis by setting a target of x number of audits per annum; but then what should x be, what counts as audit,

Table 1.1. Lincolnshire MAAG audit progress during 1991–2

		Current Status				
		No audit activity	First audit planned	First audit in progress	One or more completed	**Totals**
Status at first visit	No audit activity	3	7	14	3	27
	First audit planned		7	14	7	28
	First audit in progress			7	6	13
	One or more completed				39	39
	Totals (one practice not yet visited)	3	14	35	55	107

Source: Lincolnshire MAAG annual report.[22]

and how should topics be selected? The answers depend on where the real value of audit is thought to lie.

The value of audit

Is the process of doing audit the most important thing? Is audit valuable primarily as a means of assessing quality of care and identifying opportunities for improvement? Or is the problem-solving potential of audit its greatest asset? Each MAAG, each practice and each individual will weigh these functions of audit differently, and their criteria for deciding what to audit will correspondingly vary (see box 1.3, *choosing topics for audit*). For those primarily concerned with the process, the choice of audit topics may be relatively arbitrary and opportunistic. Those who regard audit as a measure of quality in practice may seek to achieve a balanced and representative portfolio of audit topics. Those most concerned with problem-solving will use audit as an instrumental, troubleshooting tool.

Limitations of audit

Whichever of these rationales is chosen for doing audit, there are some potential limitations to its use which need to be acknowledged and avoided. First, there is the risk that topics are chosen because they are easy or interesting to audit, rather than because they are necessarily important to the practice. Aspects of care for which data already exist in the records or are easily enumerated will tend to be early candidates for audit, whether or not they are causing major concern. Secondly, some important aspects of practice may be neglected entirely because they are not susceptible to audit. Audit can certainly help to assess the quality of care, but may not be feasible in some of the areas that are most in need of improvement. Thirdly, important problems may be tackled ineffectually through audit, when they could be dealt with more satisfactorily in some other way. For example, audit may improve group dynamics in the primary care team but, in some circumstances, explicit help with group working might be a more direct and effective way of achieving the same end.

Conclusion

If audit is to be put to really effective use in the development of primary care, it needs to be employed selectively, not as an end in itself, but on the grounds that it is the best means of achieving whatever change is required. Where audit is not appropriate, it should be rejected in favour of other methods of bringing about the desired change. To make such judgements demands a new perspective in the longer term, whereby audit is shifted out of the spotlight and the development objectives become the focus of attention. The central preoccupation 'we must audit – what can we audit?' is then replaced by a new set of questions: 'we want to (improve our care of epileptic patients; learn to communicate better; develop better relationships with the social services) how can we do this? can we use audit to help us get there?'. In the following chapters we look at audit from this new perspective, exploring the various dimensions of change and development in primary care and looking at ways in which audit may be used effectively to move things forward in these areas.

1.13 Choosing topics for audit

Audit as a valuable process

Doing audit in any aspect of practice can produce benefits in terms of critical thinking, group dynamics, awareness of the need for better record-keeping, etc., which may have valuable repercussions. If these effects are a priority, the important thing about audit is to be doing it at all. Subjects for audit need to be interesting, feasible and compatible with the practice ethos. Beyond these basic practical requirements, however, the particular choice of topic and the completion of the audit cycle are of secondary importance, so long as the activity produces spin-off benefits of some kind.

Audit as a means to assessing quality of care

It is clearly not practicable to audit everything done by health professionals. Given this, it has been suggested that certain "tracer conditions" may be selected for study on the grounds that they are representative of the care offered and are amenable to audit. Tracers do not have to be clinical conditions. The report of the North of England Study of Standards and Performance in General Practice[30] specified criteria for selecting a tracer condition as follows:

- ❑ it should be easy to define;
- ❑ it should have a significant functional impact on affected patients;
- ❑ it should be amenable to improvement by medical care;
- ❑ there should be a sound basis for discriminating between good and less good care for the condition;
- ❑ the effects of non-medical factors on the condition should be adequately understood.

The authors suggest the compilation of a portfolio of tracer conditions for study over a period of years, which would cover the morbidity presented to the practice team, the skills exercised by the team, and the resources used by the team. 'In the long term, aspects of practice organisation as well as direct patient care should form the focus of audit. Both chronic and acute conditions should be considered. In summary, the practice audit plan should reflect the practice work-load and case-mix.'

Audit as a tool for solving problems

Learning to do audit adds a useful tool to a practice's repertoire of methods for tackling problems but it must be used selectively. If audit is actually going to bring about improvements the choice of topic is critical. Baker has suggested that the most important criterion for choosing to do an audit is that it is undertaken to deal with an acknowledged problem.[6] He defines a problem as a deficiency or deviation that has been categorised by the members of the practice as needing action. Baker argues that audits set up through compulsion or curiosity or for purely educational purposes are ineffective 'because they almost always tackle subjects most participants do not accept as problems, and even if they do their practices may not. Any deficiencies that are disclosed will not be corrected unless the practice agrees that they represent an important problem that must be corrected.'

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CHAPTER 2
PROFESSIONAL DEVELOPMENT

Professional development is a term with strongly positive connotations that usually refers to attempts by individuals to become better practitioners, to extend themselves beyond the basic requirements of their job or to make progress in their chosen career. It implies a willingness to continue learning once basic training requirements have been met, not just to 'keep up to scratch' but to keep moving forward by acquiring and applying new knowledge and skills. Ideally, basic professional education produces practitioners who are not only competent but are also able to adapt to change, are motivated to pursue new interests, and able to recognise and remedy deficiencies in their performance.

The term 'professional development' is also used to describe attempts to ensure that a profession as a whole continues to adapt to changing circumstances, respond to new demands, adopt technological and scientific advances, incorporate new ideas, and is seen to be striving to provide a high quality service. The role of professional organisations and their leaders is to shape the profession's identity and public image and maintain its place in society. Although professionals have a strong preference for self-regulation, change is often generated by external pressures such as public or political opinion, legislation and organisational change rather than by pressure from members of the profession themselves.

Part of a profession's strategy for collective development must be to ensure that its members have opportunities for personal and professional development. This is usually achieved by setting up structures to provide continuing education and training and by negotiating terms of service that require or encourage participation in educational activities. In most professions and occupations, decisions about furthering personal and professional development are typically left to individual practitioners. The process of continued learning about effective practice ha s traditionally been 'private, tacit and ephemeral' for professionals, in contrast with scientists who typically use methods that are more 'public, explicit and cumulative'.[1] However, this is changing rapidly as government and the public demand greater accountability and more explicit standards of practice from all the professions.

How can practitioners demonstrate their continuing professional development? One difficulty for some professions is that after training is completed and practitioners are admitted to the profession there is neither a formal career structure nor benchmarks that give a clear indication of an individual's progress. In general practice this is particularly striking:

> *When doctors become principals in practice the basic conditions of work will remain similar from the day they enter practice to the day they retire. Changes may occur at the margins – a doctor may work up to senior partner and become a trainer or course organiser; have new premises to move to or a new computer to install; and have different patients to see at different phases of their lives – but there is little progression and little change in the pattern of their work.*[2]

The prospects are similar for other practitioners in primary health care, such as community nurses and the various therapists, if they want to continue to work directly with patients and clients rather than move into management. Their professional development must be assessed by means other than traditional hierarchy progression. Most methods of assessing competence, performance and progress rely on the judgements of individuals themselves, their peers or their managers.

The problems experienced by some GPs because of their conditions of work and the lack of a

clear career structure are well-documented. Pressure of work, isolation from colleagues, uncertainty about their role, low morale and lack of job satisfaction are commonly reported. Some opt out of professional development altogether, coping with boredom and stagnation by finding stimulation outside their day-to-day work. Growing numbers are joining peer groups of various kinds to overcome their isolation, gain moral support and stimulate learning. Opportunities for growth and development may also come from specialising, undertaking research, becoming a trainer or teacher, taking on managerial responsibilities, or getting involved in professional or organisational politics. The majority, however, look to organised continuing education to provide the contact with peers and the intellectual stimulation and challenges which keep them moving forward.

Audit and professional development

For many years the RCGP has been promoting performance review and audit as essential educational activities which should play a central part in postgraduate training. Audit, as an individual and group activity, has been hailed as giving practitioners a means of describing and reflecting on their practice and making learning relevant to the 'swamp of everyday reality' that is primary care.[3] Taking part in audit can expose people to ideas and stimulate new interests, boost self-esteem, help individuals to recognise gaps in their knowledge and skills and motivate them to make their practice more effective.

The RCGP's Quality Initiative, launched in 1983, and subsequent national developments explicitly linked performance review, education and professional development, seeing them as instrumental in raising standards of care. 'Self assessment was regarded as a fundamental attribute of a professional person and as the basis for personal professional development. Similarly, peer assessment was seen as the foundation of professional self regulation.'[4] The College successfully created a climate in which audit was tried by increasing numbers of GPs. A variety of methods were tested, and gradually began to be incorporated into everyday practice.

At the same time, complementary changes were taking place in relation to continuing education for GPs. Wood has described the trend as moving away from GPs attending activities organised by postgraduate centres, with their emphasis on transmitting new knowledge.[5] Instead GPs are increasingly taking part in a variety of practice-based and small group activities, with participants themselves identifying educational needs and defining the content and style of training. The introduction of the PGEA with the 1990 GP contract consolidated these developments. Under this scheme GPs can claim an annual allowance of £2,025 for attending 25 days of PGEA accredited courses over a five year period in the areas of health promotion, disease management and service management.[6] A wide range of activities including those relating to the development of audit within the practice now count as postgraduate education for the purposes of the allowance, and in-practice education is specifically encouraged.[7]

Experience in audit is not yet a formal requirement in vocational training for general practice, or for accreditation as a GP trainer, though it is included in the syllabus for membership of the RCGP. However, involvement in audit, and the ability to demonstrate competence in and commitment to reviewing and improving practice, is certainly becoming regarded as a significant asset when it comes to career advancement.

For most GPs, the primary reason for doing audit is to develop personal interests, to increase their satisfaction with a particular area of work, or as part of wider efforts to improve the quality of their practice as a whole. In these circumstances, the fact that they are pursuing these objectives through doing audit may be incidental. What is important is that it helps achieve their goals. In other cases, the exploration, development and evaluation of audit

methods is itself the focus of interest. In the discussion that follows we illustrate the variety of ways in which involvement with audit can contribute to the pursuit of personal and professional development in primary care. We begin by looking at some of the audit initiatives of practitioners working on their own and then go on to consider the role of audit in professional development work in a group setting beyond the individual practice. The chapter concludes with some general observations about audit and professional development.

Individually initiated audit

The pursuit of personal or professional development on an individual basis, whether through audit or by any other means, has some obvious advantages. Independent projects allow enthusiasts to race ahead because they are not tied to the slower pace of others. They enable people to pursue idiosyncratic interests that others may not share. They require less cooperation than working in a larger group. Individually initiated activities involving audit may be large scale or very modest; audit may be a central focus or a minor component of the whole.

Developing audit methods

At one end of the scale are projects which, although initiated by individuals, are concerned with professional development in wider terms with relevance well beyond the individual practice. One such example of audit-related work in the context of a strong academic link is the questionnaire developed by Baker for assessing patient satisfaction with consultations in general practice.[8] The work was carried out under the auspices of the Bristol University quality assurance project. The questionnaire was developed and refined in a single group practice and various versions were tested on different groups of patients consulting during the development period. The purpose of the exercise was not to find out how satisfied these particular patients were with their doctors' care, nor to audit the consultation procedures in this particular practice, but rather to generate a valid tool for more widespread use in research, medical education and audit in general practice.

In contrast, Hart and Humphreys' retrospective audit of deaths in their practice was intended from the start to have both local and more widespread relevance.[9] Their immediate purpose was to identify those deaths which appeared to have had avoidable casual factors, and to allocate responsibility for the avoidable causes between patients, hospitals and others. Through informal study of any errors that might be attributable to the activities of the practice and by directing local attention to the need for action by the patients themselves, they aimed to improve the care of their own patients. An additional aim, was to demonstrate to other primary care teams the potential benefits to themselves and their populations of devising and adapting similar procedures for self-criticism.

Using audit to improve a service

In both the above examples, a main concern is with the methodology of audit and how it can be used to assess or improve care in different areas. However, many of the pioneers of general practice audit and those who have subsequently become enthusiasts began auditing, not out of any intrinsic interest in the process, but simply because audit offered a means to explore areas of their work which mattered to them. In such cases, audit *per se* is neither the first nor the most important focus of the work. Taylor's work on the care of patients with epilepsy is a good illustration of how audit may fit into a wider programme of development work, both arising from and feeding into other development activities (see *Epilepsy care in Doncaster*, example 4.3, page 55). Having a particular interest in epilepsy for personal reasons, he had gradually been changing the management of epilepsy in his practice over several years. An invitation to give a lecture in 1980 prompted him to audit the records of patients with epilepsy in his practice for discussion in the lecture.[10] Taylor stresses that the external demand of the lecture led to the audit – his main interest was in improving services rather than in doing audit for its own sake. A re-audit in 1986 was provoked by curiosity to find out whether the changes introduced in the period immediately before the

first audit had been maintained.[11] Continuing interest in improving the care of epileptic patients in his practice and the involvement with audit that has gone with that produced a degree of expertise about epilepsy which has subsequently led him both into research and more broadly based service development. Taylor's view is that audit itself is of no great interest to most GPs, but that where people are committed to improving a service it has an obvious role to play.

Using audit to improve morale

The examples above were all initiated by GPs concerned with professional or service development beyond the care of their own patients. They also involved a degree of commitment that probably exceeds the resources and energies of most GPs. Both Baker and Hart had external support for their research; Taylor is an acknowledged evangelist where epilepsy is concerned. In many cases, ambitions are more modest and projects undertaken for the purpose of personal development are just that. They are not intended to be of general relevance beyond the individual, let alone beyond the practice. Moreover, development does not always mean actively moving forward into new areas or developing new competences. It may simply involve learning to stay afloat in changing circumstances, consolidating existing skills, or finding ways of coping with problems that are unlikely to go away. The audit of repeat prescriptions discussed in example 2.1 shows how audit was used by one GP to reassure himself that he was doing his best for his elderly patients and thereby to strengthen his own morale at a time when it had begun to falter.

Given the traditional individualism and independence of general practice, there will always be some who prefer to work on their own. In some cases, the unusual or personal nature of an audit project may itself demand an individual approach. But for many people the benefits of independent work mentioned earlier are outweighed by the disadvantages of working alone. The most obvious of these is the lack of support, stimulation and encouragement that may be gained from engaging with other people

2.1 Audit of repeat prescriptions

A GP who was growing older alongside his patients felt discouraged about the way his practice had changed as the years went by, with repeat prescriptions constituting an increasing proportion of his patient care. He decided to audit his repeat prescriptions to find out whether they were being given appropriately and to rectify any errors that might be identified.

He found there was a mismatch in some cases between what patients should be getting and what they were in fact receiving. He traced the problem to certain errors and delays occurring in the interval between his writing of a new prescription and the point at which the computer entry was updated. As a safeguard for his patients he therefore devised and introduced a more streamlined and reliable procedure for ensuring accurate and speedy computer recording of prescription changes.

This was a successful audit in terms of what it set out to do. The GP's own morale was boosted, because the decision to look at repeat prescriptions marked a coming to terms with the new priorities in his ageing practice and enabled him to feel that he was doing his best for his patients. Patient care was itself improved,

because the repeat prescription procedure was made more reliable.

However, the benefits of the audit could have been extended further than they were. The errors identified were not caused by faulty prescribing, but arose through inefficiency on the way to revising the computer entries. Since all the partners used similar procedures for processing their prescriptions, and all computer data were handled by one member of staff, it seems highly likely that similar errors would have occurred in the repeat prescriptions of the other partners too. Apparently it did not occur to the GP who carried out the audit to share his findings with his partners, nor to suggest that the new procedure should be implemented in the practice as a whole.

The failure to generalise the findings may perhaps be explained by the very individual focus of the initial concern. Repeat prescriptions became an issue for this GP because of his own life stage and that of his patients; they had not been identified as a practice problem. The GP was anxious about what he was doing on his own account and set about auditing with a view to investigating his own potential shortcomings; he was not thinking in terms of the practice as a whole. In these circumstances, he simply did not recognise some of the implications of his findings, although their wider relevance may seem obvious to others.

in a shared undertaking. For those who prefer collaborative work, there is a range of different ways of pursuing personal or professional development through audit in a group setting in primary care. These are discussed below.

Collaborative audit

As with activities undertaken individually, audit may be the main concern or only a minor component of group work aimed at professional development. Where audit is the main preoccupation, the focus of interest may lie with the development and evaluation of the audit methodology itself, with learning about what can be done with audit in a variety of areas, or with using audit to investigate one particular area of practice.

Developing audit methods

Interest in developing audit methodology implies a strong research orientation, which is exemplified by example 2.2. This major study, which took place over a period of several years beginning in 1982, involved one in six of all GP principles in the Northern region, although not all of these took part in the group work component of the study. Participation in the study was voluntary, and was intended to be educational, but the nature of that participation was determined mainly by the exigencies of the study design, rather than the needs or wishes of the GPs involved. Most importantly, the topics for which standards were set were decided externally and groups had no choice about which ones they worked on.

In retrospect, the study organisers acknowledged that self-selection of topics would undoubtedly be preferable from the point of view of those taking part in standard setting exercises (although they also identified some of the difficulties in choosing workable topics). Nevertheless, the majority of the participants found the experience of group work beneficial and, in terms of its broad research objectives, the study produced much important information about the use and value of audit in general practice. [13,14]

2.2 The North of England Study of Standards and Performance in General Practice

The North of England Study was set up in 1982 to measure the effect of standard setting on the process and outcome of care. The study was designed and set up jointly by the Division of General Practice of the Northern Regional Postgraduate Institute for Medicine and Dentistry and the Department of Child Health and the Health Care Research Unit of the University of Newcastle upon Tyne. It was funded by the Department of Health.[12,13,14]

Ninety-two GP trainers from the Northern region took part, 84 of them for the whole five years of the study. The aims of the study were both educational - to develop methods for setting clinical standards for good performance and to assess clinical performance by comparing it with these standards - and evaluative - to estimate the effects of setting standards and of receiving feedback, and to evaluate the costs and benefits of these two activities.

Five common problems of childhood were chosen for the study: acute cough, acute vomiting, recurrent wheezy chest, itchy rash and bedwetting. There were also five 'reserve' conditions: acute diarrhoea, acute earache, febrile fits and convulsions, recurrent abdominal pain and chronic handicap. The basic design was that of a 'before-and-after' study. Baseline data were collected over a period of one year in each study practice. GP trainers then met together in ten small groups to set clinical standards for one 'reserve' condition and one of the five study conditions. This was then followed by a further year of data collection in each practice. Five mixed groups consisting of GP trainers and paediatricians and resourced by a member of the research team also met to set standards.

The trainer groups were not able to choose which conditions they wished to work on, but they were free to work out their own standards without external direction.

All the groups that focused on a symptomatic condition were successful in generating a consensus standard with which the group were satisfied. The only unsuccessful attempts were the three that focused on chronic handicap – a diffuse and difficult non-symptomatic condition. There were substantial variations in the ways groups worked and in the structure and content of the standards they produced.

Sixty one per cent of the trainers involved in the project felt that standard-setting had improved their patient care and 32 per cent thought they had modified their own practice in relation to management of the particular condition for which they had been involved in setting a standard. The findings confirmed that there were indeed significant improvements in clinical practice among those doctors involved in setting standards for the five study conditions. However, there was no evidence of a ripple effect from participation in the study. The participants did not change their practice significantly in any area of work except the one in which they were explicitly involved in setting a standard.

Most of the participants said that, had they known at the beginning what the study would involve, they would still have taken part. Apart from improving their clinical practice, the group work had been beneficial because it was thought-provoking, and increased their knowledge and confidence. Nevertheless, some participants felt that the beneficial output was fairly small compared with the amount of input required. The great majority of the trainer groups were brought together specifically for the North of England Study but, in one case, an existing group was co-opted to the study. This particular group seemed to feel that the requirement to set standards for its allocated conditions was something of an imposition and was notably less positive about the task.

Those in mixed groups were generally more enthusiastic than those in trainers' groups about the quality of their group work. The research team concluded that the success of the mixed groups could be attributed largely to the presence of a member of the research team, who provided a technical resource that trainer groups lacked.

(A workshop on the North of England Study at the King's Fund Centre in November 1991 provided some of the information about this study.)

Learning about audit

Where the main objective of doing audit is for those involved to learn about the process and to see what can be gained from undertaking it, the experiential aspects are of central importance. In these circumstances, working together in a group can have a number of advantages. The experiences of those involved in setting up the West End Audit Group (WEAG) in Newcastle offer a good illustration of the benefits, as well as some of the difficulties encountered in exploring audit collectively (see example 2.3). Through trial and error the group learned a lot about the practical requirements of doing audit and the pros and cons of various different approaches. They also got to know each other well and the group's meetings became enjoyable and supportive events. On those occasions when audit projects went off course, the positive aspects of the group provided some of the impetus to keep going.

The main problem for this group – and others with a similarly open brief 'to learn about audit' have had the same experience – was to find topics and audit methods that were of equal interest to everybody. The WEAG appears to have coped with this difficulty so far, but other audit groups have certainly fallen apart over this issue. One method of avoiding the problem is to convene a group from the start on the basis of a shared common interest in a specific approach to audit (e.g. developing guidelines) or a particular aspect of practice (e.g. use of staff time). With a narrower brief the group may choose to be quite shortlived. Topic-based audit groups thus offer the possibility of exploring audit with like-minded people in a variety of different areas, but they are less likely to provide the particular benefits of familiarity that come from collaborating closely over a period of time (see example 2.4).

Peer group work

Groups like those discussed above, which come together specifically to work on audit, are still relatively uncommon in primary care. In the majority of cases where professional development activities are pursued in a group setting, audit is a minor and often incidental component of the group's work. Often the main purpose of the group is simply to bring people together regularly for contact, support and the discussion of mutual interests. Many of the self-constituted peer groups such as GPs' young principals' groups, local practice nurses' groups and GPs' research clubs, primarily serve such a function. Where audit is undertaken in these circumstances it may serve a purpose in maintaining the group's momentum. It is not necessarily valued for its own sake.

Nevertheless, some peer groups have found that audit suits them very well. The productiveness of the South Bedfordshire Practitioners' Group (SBPG) shows what can be achieved with audit in such a setting (see example 2.5). The sizeable population covered by group members' practices offers opportunities which the group has recognised, not only for collaborative audit but also for aetiological research. The SBPG would not be especially concerned to distinguish between audit and its other research activities, since the rationale for doing either is the same i.e. to provide a focus of activity for the group that is stimulating and interesting to pursue.

In recent years, some other practitioners' groups have taken up audit for more explicitly tactical reasons. For example, one informal group of friends had been meeting for over ten years on the basis of a common interest in the quality of care. In 1989 they decided they needed to have some examples of audit ready for when the FHSA got round to asking what was going on. They do not go in for major data collection projects, since they regard these as doomed from the start, but they now ensure that audit always features somewhere among their various activities.

Audit courses

Many of those with a more formal commitment to providing opportunities for professional development and continuing education now include audit in their programmes of events. Courses on audit are available from many sources. Often such courses set out with the specific aim of providing people with the tools

and the skills to do a successful audit which might satisfy the MAAG. Sometimes, however, such a course may act as a starting point for broader developments. For example, at a workshop on identifying topics for audit, a group of practice nurses found themselves having to tease out the differences between topics appropriate for audit and those requiring externally resourced research. As a result they generated a substantial list of research topics, based on their own needs and interests concerning nursing in primary care, which was subsequently presented to the region with requests for funding.

Audit is also used as an educational tool with more strategic aims. A GP tutor who has built audit into the courses she organises commented that one of the problems with general practice is that GPs 'are not focused people'. She feels that the process of doing audit is valuable because it encourages more convergent thinking. Getting the participants on courses to do audit is also useful because it gets them to bring their own experience to bear on the topics under discussion in a structured rather than an anecdotal way. In her view, active participation in audit is generally experienced as positive and reinforcing because it confirms that most GPs do very good work. Audit is also seen to have value in encouraging sceptical practitioners into the educational arena, by providing them with the tools to investigate politically sensitive aspects of their practice such as the effects of the GP contract. This tutor was convinced that the new PGEA arrangements are the key to getting unwilling GPs involved in educational audit. Other people, however, have expressed doubts as to whether the PGEA offers a sufficient incentive to encourage all GPs to participate in educational activities. Anecdotal reports from some FHSAs indicate that the number of GPs claiming PGEA has fallen since the first year in which it was available. There is some evidence that those who may be most in need of postgraduate education continue, despite the inducement of PGEA, to participate in the fewest accredited sessions. A recent study of GPs in the west of Scotland found that the minority of doctors who had attended insufficient sessions to claim the allowance included disproportionately large numbers of those working single-handed and those who had been qualified for over 30 years.[19]

Conclusion

The examples in this chapter illustrate a variety of ways in which audit can contribute to personal and professional development in general practice. The projects discussed vary enormously both in the scale of the undertaking and the scope of their objectives. The place of audit in these development activities is also variable. In some cases it is the central concern, in others it plays a supporting role or serves to sustain momentum in a wider enterprise. This diversity of function means that audit is seen as worthwhile, not just to audit enthusiasts but well beyond. In one way or another audit can play a part in the most diverse agendas for professional development.

With any personal and professional development activity that is undertaken voluntarily, those who are keenest are the most likely to get involved. Conversely, the least interested do the least and thus the two extremes diverge. In the past, there has been considerable variation in GPs' involvement with audit, reflecting in part the division between those involved with the RCGP and those who were not. (In 1991, 47 per cent of UK GPs were College members or fellows.) The Government's present audit initiative offers a major opportunity to alter the situation, not because it requires all GPs to participate (this in itself may act as a disincentive to some people), but rather because it places a statutory duty on each FHSA to provide support through the MAAG to every practice in the district to develop audit skills. With the encouragement and support that MAAGs are now beginning to offer, audit may provide the impetus for getting involved in wider professional development activities for many more people in primary care.

Given the multidisciplinary nature of primary care, it is important to ensure that individual professional development is coordinated with the development of the practice as a whole and

2.3 The West End Audit Group

The WEAG is a geographically based group of GPs working in the west end of Newcastle upon Tyne. It was formed in early 1989, when the general practice world had been rocked by the White Paper *Working for patients*, and the threat of compulsory audit. The three founder members each had different reasons for wanting to start a group. One was a member of the local academic department of primary care, who felt that academic GPs should be getting involved. He also wanted to be part of a support group. A second GP wanted the opportunity to compare information about practices with colleagues working in a similar inner city setting. The third founder member, although interested in audit, was primarily concerned to join a group for professional support. She was new to the area and wanted to meet others working locally. All three were influenced in part by a desire to 'steal a march' on Government and get into a position where they could resist outside intervention in audit by showing that they were already ahead of the field.

Invitations to join a group were sent to all 40 GPs in the west end of Newcastle. Of the 16 who came to the first meeting or sent apologies, 14 have continued to attend and have become the core members of the group. The organisers did not follow up or try to persuade other GPs to attend.

At the first meeting they discussed what they wanted out of the group. They were all interested in practice comparisons and decided to look at use of diagnostic services - not because there were any particular problems of access, but simply because this was a common interest. Data were collected about the use of diagnostic services by all participants for two months. It was a classic practice activity analysis type of audit, except that everyone collected the data differently. When compared, the findings were less than illuminating. It was felt that although the study had been largely a waste of time, they had 'had to do it', if only to help them understand more about the principles and practice of audit The lessons were also valuable i.e. that audit needs clear aims and uniformity of recording. As a result of the earlier failure, the group decided to focus its attention next on the management of a single condition - haemoptysis. Long discussions 'almost led to setting a standard'. They got to a position where a protocol for management could have been drawn up, but this was not formalised. However, they all felt that they had benefited from participating in the discussions. The debate about haemoptysis led to thinking about the use of X-rays. All members of the group collected information about X-rays they had requested and the reasons for wanting them. The ensuing discussion was felt to have influenced group members a lot and some at least now request X-rays less frequently.

After a year of activity, the group hit a difficult patch. There was a 'why are we here' discussion and the group tried to find a new direction. There was some difficulty identifying a common topic to study. In the end they decided to watch the RCGP video, *Who killed Susan Thompson?*, and this

stimulated an interest in case analysis. Other group members data flagged up interests in PACT (prescribing analysis and cost data) and other topics so the group decided to timetable topics for discussion. The case analysis enthusiasts almost split from the rest of the group, but it was agreed that case analysis should run alongside other discussions. The 'low point' for the group also brought out new resolutions about better chairing and agendas.

The video led to discussions about managing asthma in children, which raised questions that prompted members of the group to search the literature to try to find answers. Eventually the group produced a protocol for the management of childhood asthma. A subgroup also did some audit and standard setting on managing adult asthma in their own practices. This stimulated similar audits in other members' practices, with the help of a MAAG audit assistant. The findings of these audits were discussed with a chest physician, and this led to a joint WEAG – chest unit audit of patients attending hospital with acute asthma, which is currently underway. Other audits in progress in 1992 are on UTI diagnosis (with a local microbiology consultant), quality cervical smears, and prescribing allopurinol.

There have been a number of benefits from the group. The group members now know each other well, feel safe and able to be lighthearted. The meetings are fun, but topics are discussed seriously and often passionately. The group members have learned a lot about audit, albeit through trial and error and making their fair share of mistakes. The emphasis has been very much on personal growth and professional development - the group does not see it as part of their aim to improve the quality of primary care in the area as a whole. They have not set out to identify service deficiencies, nor to lobby for change. Halfway through the life of the group they obtained PGEA funding for their meetings. There is disagreement in the group about whether this should be necessary - the 'purists' think not.

A clear strand in the WEAG's early discussions was to establish itself as a grassroots alternative to the LMC and FHSA audit initiatives. At one point the group wrote to the FHSA chairman requesting that the FHSA consider three nominations from the group for membership of the Newcastle MAAG, but was turned down. However, one of these doctors had also been nominated by the RCGP sub-faculty and therefore became a member anyway. Another was eventually co-opted by the MAAG with the agreement of the FHSA general manager when the MAAG realised it had no women members.

At the first MAAG open day, the WEAG group gave a presentation of its experiences. Thirty six participants at the open day expressed an interest in joining a locally based audit group. The MAAG has subsequently facilitated the establishment of several such groups around Newcastle.

(An interview in October 1990 with Gail Young, Lesley Duke and John Spencer, members of the WEAG, provided this information about the group.)

of wider services. Correspondingly, general practice audit needs to link productively with broader quality assurance activities in primary care, rather than following an uncoordinated parallel track. The initial presentation of medical audit in the 1989 White Paper as a matter of internal educational and professional development for doctors did little to encourage such links. In reality, the rigid demarcation between medical and clinical audit has already broken down to some extent in the face of the complex interaction of clinical, management and resource issues in primary care. Many people now regard practice audit as a more realistic and constructive focus of activity,[20] but the structure and orientation of personal and professional development activities tends to reinforce a more segregated approach.

On an individual level, the objectives of undertaking an audit may seem so personal that, as in example 2.1, insights, however relevant, do not even get disseminated to medical colleagues, let alone to the practice as a whole. Group work avoids some of this isolation, by creating and strengthening links between colleagues in different practices. However, the very success of a group may lead to problems of a different sort, insofar as its members become separated from their own partners and practices. The enjoyment of working together on stimulating collaborative projects in a self-selected group of like-minded enthusiasts may divert the energies of the participants from the more mundane needs of their own practice. One member of the WEAG said she felt frustrated that the work of the group had not really helped her to solve problems in her own practice, although she found it extremely valuable in other ways. She sometimes resented putting time into attending group meetings which she felt might have been better invested in work that would directly benefit the practice.

Groups concerned with professional development tend to be unidisciplinary. It is also to be expected that their agendas for development will reflect a particular professional view and their major concerns will lie with the aspects of practice or the components of a service in which they are most directly involved. This chapter has demonstrated the considerable opportunities for using audit productively within such a framework. Where the concern is with the development of a practice or a service as a whole, it is necessary to take a wider view. In Chapter 3 we look beyond the development activities of particular professional groups to the wider multidisciplinary setting of the primary care team and the practice as a whole.

2.4 Topic-based audit groups

The first open meeting of Newcastle MAAG had a number of topic-based workshops. The one on surgery time was the most oversubscribed and was rated highly by the six GPs and four practice managers who participated. The problem they were set was 'How would you know whether you, as a practice, are giving enough appointments and by what standards would you judge?'

The participants found it hard to set a satisfactory standard, and a smaller group of four GPs and two practice managers agreed to meet two weeks later for further discussion.

This small, topic-based group decided to design a uniformly usable questionnaire to gather relevant information. They planned to amend a questionnaire provided by one of the members, with a view to piloting it in each their own practices. However, this proved a difficult task. It was suggested that the MAAG might employ an expert on a consultancy basis to help with the questionnaire design. Further meetings were planned to take these ideas forward.[15]

2.5 The South Bedfordshire Practitioners' Group

The SBPG arose in 1984 as a splinter group from a previous practitioners' group when the latter became too large. There are now six different practitioners' groups in the district, all involving GP users of the local general hospital. The SBPG is the only one which has published any research. The group currently consists of 16 GPs from 11 group practices. Between them they have 100,000 patients on their lists.

The SBPG has monthly meetings at which they do 'all the things other practitioners' groups do' i.e. talking about cases, talking about their partners, etc. The group serves as an important social network and a place to relax. The research and audit work is a very small part of what they do. Nevertheless they have done a fair amount in this area, including three studies which have resulted in publications: a study of childlessness in their practice populations[16], an audit of their management of urinary infections in children[17], and a retrospective analysis of the management of children with renal scars.[18] The latter was an audit of management by GPs and hospital doctors, which looked at both hospital and GP notes.

More recently, the group has been looking at aetiological factors in multiple sclerosis. The stimulus for this study came from someone who contacted the group after reading one of their articles, pointing out the research power of a GP group with notes on 100,000 patients, and suggesting a hypothesis that they might investigate.

The group do all their own scrutinising of notes for their studies, rather than delegating the work to other people, because they realise that they get more ideas and learn more by doing it themselves. They have had no external funding or support apart from a grant of £50 from the local faculty of the RCGP for the study of urinary infections and some help with statistical analysis from a statistician at North West Thames Regional Health Authority.

It is interesting to consider why the SBPG has developed so far in the direction of research, while other local practitioner groups have apparently not sought to do so. It seems that the inspiration for research, as well as the coordination and driving energy, comes largely from one member of the group, whose enthusiasm derives in part from her training (a research oriented BSc during medical school and a trainer who encouraged her to audit his own practice during vocational training).

The group does not have a systematic research plan, nor any particular commitment to audit in preference to other types of study. Ideas for projects come in part from local circumstances. For example, the opportunity for the renal scar study arose because of a clinical assistantship in paediatrics which gave the GP involved a toe in the door of the hospital and access to hospital notes. The coordinator deliberately does not push the group, but every now and then she 'gets a wild idea', and then it takes three or four meetings and a lot of donkey work and pulling together of material to produce an article. It seems that periodic publication is one of the factors that has led to the group's stability and maintained the impetus to continue. The publication in the BMJ was 'a big feather in their cap'. However, very little external interest has been expressed locally or by partners of the group's members about their research activities and publications. More interest has come from further afield.

(An interview in November 1990 with Gina Johnson, member of the SBPG, provided this information about the group.)

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CHAPTER 3
PRACTICE DEVELOPMENT

The basic operational unit of primary health care – the primary care team and the population it serves – is the focus for practice development. The practice team includes the GP partners, staff employed by them and 'attached' staff employed by the health authority (health visitor, district nurse, midwife etc.) Practice development is a joint enterprise, involving the whole team in attempts to improve quality and extend their range of services.

> *Members of a practice need to act as an integrated unit, not as separate individuals with unrelated roles. Their concern should be for the overall success of the practice team rather than their own individual functions.*[1]

Practice development includes some aspects of professional development, as individual practitioners continue to learn and progress. It may also be part of wider service development initiatives orchestrated by the health authority or FHSA, to which a practice team makes its own contribution. A distinctive feature of practice development is its concern with enhancing the effectiveness of teamworking and increasing the job satisfaction of team members as a means to improving service quality. Practice development has a dual focus, on organisation or team development (how can we work together better as a team?); and on the services provided for the practice population (how can the team do better for patients?). Activities focused on the team include team building, team management, decision making, delegation and communication. Developing services involves establishing practice policies, for example for the provision of preventive care and the systematic management of chronic illness, setting objectives, standards and targets, reviewing performance, and implementing and assessing new ways of working.

GPs often take the lead in practice development. Their independent contractor status and their prestige in relation to other team members allow them by far the greatest say in what services the practice will offer and the style of delivery. It has been argued that GPs' autonomy and control over their practices hold the potential for rapid change and innovation. While this may be true and has been realised by some practices, such individuality may also limit the possibilities for development. GPs can offer clinical expertise, leadership and inspiration, but they do not always have the skills and time necessary to create a cohesive and effective primary health care team. Practice managers are playing an increasingly important role in team building, planning developments, introducing new ways of working, and monitoring progress. Some practices have also found it useful to employ an independent 'facilitator' to help the team to adapt and change.

Facilitators employed by FHSAs and DHAs to assist practice and service development have become a familiar part of primary health care in the last five years. Well-known examples include the Oxford Heart Attack and Stroke Project, which provided facilitators to help practices set up screening programmes, train staff and audit performance.[2] Allsop has documented the varied and important work done by facilitators.[3]

Audit and practice development

The services offered by a practice team are likely to be the result of many influences on the practice. Changes may be driven by legislation, financial incentives, local health authority policies and practices, the clinical interests of team members and demands from patients. Sometimes changes are made in response to the results of systematic reviews of clinical work or practice organisation, but we suspect that this has not been a particularly powerful influence

in the past. However, now more practices are employing practice managers and are beginning to steer their future development by defining objectives, making business plans, setting criteria and standards for good care, measuring performance and actively managing change, the parallels and connections between management, development and audit are becoming increasingly apparent.

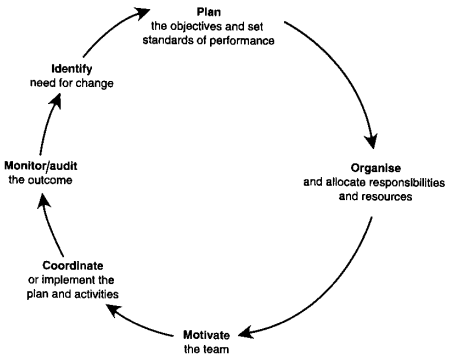
Irvine and Irvine point out that the common ground between practice management and audit includes defining objectives and setting standards, monitoring and assessment of performance and managing change.[4] Audit may be thought of as one stage in the management cycle, as shown in Figure 3.1.

Equally, the management cycle can be seen as elaborating the 'change' phase of the audit cycle. Wherever the emphasis is placed, it is clear that audit and practice development can be complementary.

> *Audit may indicate the need for change; management is the process within a practice whereby change is achieved. Moreover audit may also be a powerful and effective tool for bringing about change in an acceptable and workable manner, because it provides reliable up to date facts about a practice and its performance, the starting point for effective decision making. This is especially so when the need for change may not be obvious to or accepted by all members of the practice, or where it is going to involve demanding or uncomfortable adjustments by some individuals.*[4]

The examples in this chapter illustrate a variety of ways in which audit and practice development can be linked. In some cases audit is used primarily reactively to investigate problems and suggest solutions. In others it is a method of identifying a practice's strengths and weaknesses, demonstrating the possibilities for long-term development as well as the need for

Figure 3.1. The management cycle



Source: Irvine D, Irvine S. Making sense of audit.[4]

immediate change. Audit can also contribute to a more proactive and explicit process of developing services that begins with defining objectives and making plans to achieve them. The objectives may be generated by the primary care team itself or adopted by the team from local or national initiatives, for example to combat heart disease or increase uptake of childhood immunisations. We look in turn at problem solving with audit by the practice team; the College of Health's *Ask the patient* initiative, which involves patients in assessing a practice's services; the HEA's workshops for primary health care teams, which aim to develop preventive care through a combination of team building, planning and audit; and the use of various kinds of development plan, which offer a framework for both improving services and introducing audit. The chapter concludes with a summary of our observations about audit and practice development.

Problem solving with audit

Identification of a significant problem in a practice and a decision about whether audit would be an appropriate step towards resolving it is the starting point for this approach to audit.[5] It has been described by Baker and Presley in their practice audit plan (see example 3.1).[6] The approach offers an explicit framework

3.1 The practice audit plan

The practice audit plan developed by Baker and Presley[6] identifies three principles for successful audit:

1. Audit should be **practice-based**, involving the whole practice team and adapted to the practice's ways of working. It is not 'just a way of doing some audit in the GP's own available spare time'.

2. Audit should be **worker-centred**, guided by team members' views and concerns, and involving them in decisions about what to audit and what to do about the results. The aim is educational so that the team learns from mistakes and difficulties, without blaming individuals.

3. Audit should be **problem solving**, with an emphasis on spotting and selecting problems that the team wants to solve. Audit has a clear purpose.

This approach is unusual in that it places strong emphasis on the team developing its own framework for audit. A set of rules are agreed and written down to govern the way the practice will carry out audit and act on the findings. The aim is to ensure that all members of the practice team feel safe and confident about audit and that audit becomes an integral and continuing part of the practice's activity. Other important features of the plan are:

- ❑ a system for identifying problems in the practice;
- ❑ a method of assigning priority to problems and deciding whether audit is the right way forward;
- ❑ a system for continuous review of progress.

These aspects of preparing for and undertaking audit are usually glossed over in other accounts of audit in primary care. Methods of audit, information systems and data analysis follow from definition of the problem to be tackled.

The practice manager has a key role in the practice audit plan. She or he ensures that the plan is followed, a problem list maintained and progress recorded. The team itself discusses problems that have arisen and sets priorities for audit, by considering questions such as:

- ❑ Is the problem common?
- ❑ Does it affect patient care?
- ❑ Does it have serious consequences in terms of mortality or morbidity?
- ❑ Can it be solved using audit?
- ❑ Is it a management problem rather than an audit one?
- ❑ Is it a FHSA/DHA problem rather than a practice problem?
- ❑ Would correcting it save more money than ignoring it?
- ❑ Does the team have the skills to tackle the audit?
- ❑ Does the team feel motivated to tackle the problem?

This selection process helps to increase the likelihood that audit will:

- ❑ be undertaken appropriately, not just as a substitute for indecisive management;
- ❑ be 'owned' and followed through by the practice team;
- ❑ lead to suggestions for changes that are within the scope of the practice to implement;
- ❑ be an enjoyable and rewarding experience for participants, which builds the team's confidence and ability to solve problems and increases its morale.

for audit in a practice and shows how audit, practice management and development of services can be integrated. The key to integration is that both audit and development are seen as participative, incremental and continuous processes, with a premium placed on making relatively small-scale changes quickly. Its strengths are that the whole practice team is involved in setting the audit agenda and carrying out studies that are selected to have a high chance of leading to measurable improvements in care. Audit has a clear purpose, modest aims and carries a low risk of failure and demoralisation for the practice team. In addition, the systems and processes that support audit in this model may in themselves enhance the effectiveness of teamwork in the practice. These systems and processes may include regular team meetings, collective responsibility for spotting and reporting problems, team members being given feedback about performance, and participation in discussing problems and identifying solutions.

The emphasis of this approach is on demonstrating how audit can help to solve day-to-day practical problems faced by a primary health care team. It is less clear how audit relates to the practice team's efforts to plan longer term developments and to make more fundamental changes to organisation, staffing and delivery of services.

One obvious drawback is that poorly organised practices, unused to teamworking and without effective practice management, may not find it easy to adopt this method of audit. They may first need to introduce a basic level of practice organisation and establish multidisciplinary meetings as an infrastructure on which audit can be built. The participative style on which the practice audit plan is based could also present difficulties, because it is likely to be incompatible with the way many practices are currently run.

A further disadvantage is that patients are not directly involved in setting the practice's audit agenda. Their perceptions of problems are filtered through practice staff and may thus be given lower priority than they deserve. More direct methods of bringing patients' concerns to the fore are considered next.

Asking the patient

A method of discovering patients' views about the practices with which they are registered has been developed by the College of Health as part of its work on consumer audit (see example 3.2). Consumer audit 'reviews the quality of care provided by the health service from the patient's point of view. It establishes the patient's quality agenda through a range of observation and interview techniques, identifies and defines standards of service which patients should reasonably expect, and measures performance against those standards. It is particularly concerned with communication; looking at the quality of communication between health service providers and users, including potential users, of the service.'[8]

Following pilot work in a number of London practices, the College of Health produced an *Ask the patient* action pack which offers practices simple tools and guidelines for using a combination of observation, interviews and questionnaires to assess patients' views of services and for putting the findings into action.[7] The aim is to obtain useful qualitative and quantitative information from patients on the organisational and clinical aspects of general practice. The pack has been designed for practices to adapt and use themselves, building in 'ownership' of the exercise and thus making GPs and their staff more likely to use the feedback and implement change. *Ask the patient* offers an adaptable alternative to using cumbersome standardised patient satisfaction questionnaires, whose results are often expressed in general terms and can be difficult to translate into practical action. It is seen as making a direct contribution to practice development. With the feedback it provides 'the practice can ensure services are planned and delivered with the experiences and concerns of patients in mind'.[8]

A cross-section of patients or samples from selected groups can be included in the audit and many aspects of practice organisation and clinical care can be covered. An important benefit is that both positive and negative aspects of quality can be highlighted in confidential reports to the practice team. Results are obtained relatively quickly, in a matter of weeks, so recommendations are timely as well as specific to the current circumstances of the practice. Findings may be summarised in the practice annual report and used as a basis for setting standards of care.

A similar scheme to *Ask the patient* has been developed by East Dorset Community Health Council (CHC) and Dorset FHSA, with funding from the regional health authority.[9] A number of practices in East Dorset have collaborated with the CHC on the GP Quality Assurance Project. A CHC officer and members visit practices to review premises and services. Then a questionnaire is sent to a sample of patients and the responses are analysed by the CHC. A confidential report of the findings is prepared for the practice. The scheme has been found to be acceptable and useful to the practices which have taken part and improvements to premises and services have been made as a result of the audits. For example, practices have rearranged surgery times, started a newsletter, built a ramp to improve access, and increased the number of telephone lines.

3.2 Ask the patient

This approach to obtaining feedback from patients has been developed by the College of Health.[7,8] The essential components of *Ask the patient* are:

- **observation** in the waiting room by an independent lay person, who assesses facilities and services from the patients' point of view using a prepared checklist;
- **semi-structured interviews** carried out by an independent lay person, who asks a sample of patients attending clinics or surgeries about their experiences and their views on services;
- **patient questionnaires** to mail or hand out, designed to suit the particular needs of the practice, which allow a larger number of patients to make their views known.

A report is written at each stage of the process and fed back to the practice team, which is asked to discuss the findings. Feedback is very specific and may include recommendations for change. The team decides which issues need immediate action or require investigation in more depth.

Although outside help is an essential feature of *Ask the patient*, the action pack places emphasis on practice staff being informed and involved at all stages of the process. Indeed, the College of Health's pilot studies found that input from practice staff in planning and carrying out the audit was crucial to gathering information successfully. The team should be encouraged to participate and to see the process 'as a normal part of audit and quality review' not as a 'threat or personal criticism'.

Results from the pilot studies showed that practices had taken action as a result of consumer audit findings, making improvements to premises (for example, soundproofing consulting rooms and altering the layout of reception areas to increase privacy), changing practice organisation (for example, appointment systems), initiating service developments (for example, introducing new clinic sessions) and making plans for further audit.

A strength of both these approaches – and a potential obstacle to getting practices to participate – is that outside help is needed in the form of independent, experienced observers, skilled interviewers, and someone who can analyse and write up the study findings. The positive side of involving outsiders is their objectivity and ability to stimulate with new ideas. This needs to be carefully weighed against the possible negative effects i.e. the financial costs, perceived intrusiveness and increased threat posed by an external audit process.

The majority of practices have the necessary staff and administrative skills to organise a consumer audit, but fewer will have experience of translating audit findings into action or responding to feedback from users. The College of Health's pilot studies and the work in East Dorset suggest that consumer audit could be enhanced by some form of collective organisation. This would facilitate involvement of practices in the scheme and give them access to help in planning, carrying out and responding to consumer audit, so that they gain maximum benefit from the process. FHSAs, CHCs, DHAs and local voluntary organisations may be interested in encouraging this kind of development. Their involvement could help to ensure that practices complete the feedback loop by translating consumer audit findings into practical action.

Team workshops

Introducing multidisciplinary audit to a practice may be easier and more likely to lead to improve-ments in services if the practice team is already working together effectively, or can be helped to do so. The HEA has devised and evaluated an approach to developing prevention and health promotion in primary care which combines team building, multidisciplinary review of services (audit) and a problem-solving approach to jointly planning the services provided by a practice.[10] It is known as the *Primary Health Care Team Workshop Strategy* and has now been tested by a large number of teams from many parts of the country (see example 3.3).

The findings of the evaluation showed that there were many positive outcomes for the teams that took part in the two-day residential workshops. Participants greatly appreciated the chance to get away from their workplaces to review current activities and make realistic plans for the future. All the teams completed their task successfully and developed a framework for prevention and health promotion by the practice. When teams were followed up some months after the workshops, they were attempting to implement and monitor their plans, often after making modifications in the light of experience. They reported that teamwork had improved as a result of clarifying the roles and responsibilities of team members, better practice organisation, improved communication, more frequent or more productive team meetings and enhanced motivation. However, these improvements need to be set against evidence that in most practices teamworking was not well-developed: 'feedback from the events suggests that for many of the teams, the workshop experience represents the first real opportunity to take time to plan together – indeed for many of the teams practice meetings are a rare event. In other teams, whilst they may have meetings, feedback suggests that such meetings are not always very productive.'[10]

One of the main strengths of the team workshop strategy is that it recognises that team development and service development within a practice are mutually reinforcing and accords them equal emphasis. Given the evidence that teamwork in most practices is rudimentary, it is particularly important that teams are allowed to build up the understanding, trust and respect necessary to underpin their attempts to audit and plan together. The workshops appear to have been particularly successful at stimulating improved teamworking on prevention and health promotion.

A further advantage is that the workshops encourage exchange of ideas between practices,

3.3 The HEA's Primary Health Care Team Workshop Strategy

A national programme of workshops for members of primary care teams was initiated and coordinated by the HEA, but organised locally in collaboration with FHSAs and DHAs.[10,11] Team members spend two and a half days away from their practices working out their own detailed plans for prevention and health promotion.

A local planning group is set up to organise each workshop, which is usually residential. A small number of practices, seven on average, are recruited to take part. They are asked to nominate at least three team members from the core group of GP, practice nurse, community nurse and practice manager or administrator. Sometimes the nominated members meet before the workshop to prepare for the event. At the workshop keynote speakers provide limited input, for example giving information about health problems in the district or introducing the tasks teams are to undertake. Most of the time is devoted to practice teams working together to develop a plan for their own health promotion activities. Leaders and facilitators help them with this task.

The workshops are based on a philosophy of participative learning, with team members contributing their own skills and experience. The organisers have discovered that giving teams maximum time to work together is the best use of the workshops. There is also time for discussion outside the practice team in order to compare experiences and exchange ideas in a supportive and non-competitive atmosphere.

Audit and development are linked in the tasks set for the teams. They are asked to start by reviewing and assessing their current health promotion activities. From this audit they identify what they would like to achieve and their goal is to prepare a detailed plan that will enable them to do so. As an integral part of this plan they must specify ways of maintaining and developing multidisciplinary teamwork, decide how to monitor their performance and assess effectiveness, and work out how to manage change within the practice as a whole.

On the final day the teams present their plans in a plenary session, which may include specially invited participants. More than six months after the workshop a follow-up session is held to discuss progress.

The initial focus of the HEA programme was prevention of coronary heart disease and this was reflected in the plans developed by the majority of teams. However, the programme has now been broadened and teams choose their own topics, for example the management of diabetes and asthma, care of elderly people, immunisation and menopause screening.

unlike many other practice development activities which focus exclusively on the situation within the practice. Not only do the workshops offer teams 'protected time' for team building, they also expose participants to new ideas and provide resources, in the form of information and facilitation, to help them achieve their goals.

A disadvantage of the workshops is that they require a number of team members to be away from the practice together for several days - a requirement which may be impractical for those working in single-handed or small practices, where there is little flexibility of staffing. Locum cover for GPs may be the easiest problem to overcome. Short-term replacements for nurses, receptionists and administrative staff may be more difficult to find and unsatisfactory in practice.

The team workshops were never intended as a means of training about clinical audit, but the process brings out the obvious connections between audit and practice development. Review of current services is the starting point for setting objectives; development plans for achieving objectives include finding ways of monitoring performance. In future, audit may become a more prominent feature of the workshops as health promotion in primary care expands and teams increase their experience of collecting information to monitor performance and evaluate outcomes.

The HEA has begun to devolve responsibility for the team workshops initiative to local level, with the aim that it becomes self-sustaining. Workshops are now planned by specially trained local organising teams (LOTs) whose members represent organisations and professions with responsibility for health promotion.[11] LOTs, with their local knowledge, networks and combination of skills backed by the resources of FHSAs and DHAs, have successfully recruited many primary care teams to take part in workshops. Even more importantly, they are also able to offer them continuing support for their health promotion activities.

Although the team workshops were pioneered in the field of health promotion, the HEA's strategy could clearly be adapted to encourage developments in other aspects of primary health care. LOTs are a valuable model for multi-agency and multidisciplinary working and the team approach to developing the services provided by a practice has much to recommend it.

Development plans, practice annual reports and manifestos

Written development plans, similar to those produced by the teams taking part in the HEA workshops, are becoming increasingly familiar to those working in primary health care. 'A "development plan" is the description of a practice's current situation, the team's aspirations, and the means of getting from here to there, and assessing whether it has arrived.'[4] Plans are often incorporated, in one form or another, into a practice's annual report.

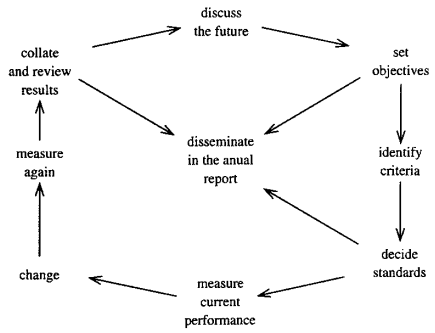
Keeble *et al* have argued convincingly that the annual report should be the focus for a practice's quality assurance, management and planning activities, 'the hub of objective setting and performance review'.[12] They advocate a version of 'management by objectives' for general practice, in which the annual report is 'an instrument for participation and progress rather than simply a means of checking on expenditure and reflecting on the past'. Practice management by objectives is explained in example 3.4.

A slightly different approach to the process of defining a practice's aims and plans for the future has been described by a team from Newcastle upon Tyne.[13] For two years the Adelaide Medical Centre Primary Health Care Team discussed what they were trying to achieve and how their success could be measured. The result of their deliberations was a manifesto setting out aims and objectives which were 'realistic, practical and achievable' (but not comprehensive) and

3.4 Practice management by objectives

Many practices are realising that the annual report can be a vehicle for setting and publicising objectives, for reviewing performance and planning changes which will lead to improvements in the quality of services. Keeble and colleagues[12] have shown how it can become 'an integral and dynamic part of the performance review process', as shown below.

Figure 3.2. The annual report as the hub of objective setting and performance review



Practice staff meet to discuss future plans. 'All staff should meet together, at least annually, to decide upon the objectives to be pursued in the following year and to review progress of the previous year's objectives. Some practices might wish to include interested patients in this process.' Judicious choice of a limited number of the 'right' objectives is thought to be one of the keys to the success of the scheme. Audit must be seen by busy practice staff as a feasible and worthwhile activity, and a checklist is offered to guide the planning process.

Planning Checklist

1. Involve all staff (and patients) from the start.
2. Obtain agreement on objectives before proceeding - carry the others with you.
3. Start with a few simple objectives - do not bite off more than you can chew.
4. Choose objectives which will 'throw light on' the different aspects of quality, especially medical and managerial effectiveness and patient satisfaction.
5. Whenever possible choose objectives which will highlight the outcome (results) of your practice.
6. Only set objectives which are measurable.
7. Decide on standards in advance.
8. Where possible automate collection of data for measuring performance (data gathering should not take up too much time).
9. Prioritise different objectives every year or so in order to avoid boredom.
10. Ensure that performance review is carried out in a non-threatening manner. The purpose of the exercise is to improve the quality of practice, not to find victims to blame.

offered a framework for audit and the development of services (see example 3.5, *A primary health care team manifesto*).

In many practices the process of making plans and compiling reports falls far short of these examples, which make an explicit link between practice development and audit. Most practice annual reports have concentrated on descriptions of staff, services and activity rates. They rarely mention plans, objectives, targets or outcomes. Often there is little evidence of input from the practice team. [14,15]

Now that it is a contractual obligation for GPs to provide certain items of information to FHSAs in an 'annual report', some FHSA managers are using this opportunity to encourage practices to produce a document that will help with service planning and development. Oxfordshire FHSA's approach is to convince practices that there is value in preparing 'not so much an annual report, which is by definition a retrospective document, but an annual plan which sets out the practice's objectives and priorities for the year ahead, for performance review and to make a case for FHSA funding. The document would also assist with clinical audit and enhance staff participation.'[16]

The Oxford General Practice Outcomes Project (TOGPOP) has been working to define a limited set of feasible and relevant objectives and valid and reliable measures of performance that could be easily obtained by all practices. This data could form the core of the practice annual report 'with last year's figures, this year's achievements and next year's targets in a tabular or map form and the reasons for them discussed'.[17] TOGPOP can also provide comparative data that would enable practices to locate their performance in relation to the average and range of results from a peer group. Although the value of comparative information is emphasised, the project also recognises the value in practitioners setting their own objectives and standards rather than having them imposed from outside. [12]

A written set of objectives, a development plan or a manifesto is tangible evidence that a practice is thinking constructively about the services it offers and is planning ahead. Producing a document offers a structure for involving the whole practice team. As Irvine and Irvine point out, 'making the plan explicit clarifies the issues facing a practice team and enables it to identify workable solutions. The thought and discussion involved in generating a business plan are as important as the outcome. Writing down a development plan is a visible sign of the planning process. It can provide a secure framework within which the practice's audit activities can be planned and prioritized.'[4]

This approach, like the practice audit plan, brings together audit and the development of services, and has many of the same advantages for the practice team. However, the emphasis here is usually on setting longer term goals for practice development with a horizon of years rather than months. Thus it is potentially both a more rewarding and more risky venture for the team than identifying and tackling pressing problems in a piecemeal fashion.

The disadvantages are also similar to those of the practice audit plan. A team unused to a partici-pative style of working may feel that decisions are being imposed on them by the more dominant members in the practice if the process is rushed. The two years the Adelaide Medical Centre team invested in working towards agreement on a manifesto may give a realistic estimate of the time needed for a team to become used to this type of planning process and to build the necessary sense of ownership of the product.

Although it is desirable that patients should have a say in planning services, setting objectives and monitoring the performance of a practice, the approaches described here do not specify how this is to be achieved. There is clearly scope for including methods such as patient surveys and *Ask the patient* studies in development plans, and patient representatives could be involved in practice meetings to discuss reports and plans.[18]

3.5 A primary health care team manifesto

Over a two year period, the Adelaide Medical Centre Primary Health Care Team in inner city Newcastle upon Tyne met to discuss what they were trying to achieve and how success could be measured. They constructed a manifesto which defined the shared aims and objectives of the team. Their report of the process of debating the questions and drafting the manifesto emphasises that it was a team building exercise, resulting in team members gaining a sense of ownership of the plan and helping them work towards common goals.[13]

'The production of the manifesto was time-consuming for all team members, but the meetings allowed members to ventilate their ideas and views. Most of the objectives were derived from the meetings of the whole team, although those concerning prescribing were produced by the doctors alone.'

Objectives set out in the manifesto cover services provided by the practice, teamwork, teaching and audit. High priority is given to personal and professional development for team members:

'Each team member will be offered feedback and discussion as a means of personal development at least once yearly.'

'Each team member will be encouraged and expected to pursue their own further education and training.'

It is also intended to use the manifesto as a basis for individual staff appraisal and to help the practice achieve a more structured approach to team member education and training.

Writing the manifesto has also stimulated, or at least has been associated with, a variety of developments in organisation and management of the practice. 'From a management perspective the manifesto has only been the beginning of a process which will lead to the development of a strategic plan for the team with appropriate supporting management structure. To this end the post of practice manager has been upgraded, the internal administrative structure reorganised and one partner has been given responsibility as "executive partner". The executive partner and the practice manager axis is seen as crucial to the implementation and monitoring of the manifesto.'

So far most of the objectives set by the team have not been formally audited, but they promise 'a thorough review of the manifesto with a supporting audit of all the objectives ... in 1992.'

Conclusion

The examples in this chapter reinforce the view that audit and practice development can be interdependent and complementary. They show how audit can help to solve day-to-day problems identified by the practice team; offer a means of identifying and responding to patients' views of the practice; and contribute to introducing new services and planning for the future. The case studies also highlight the following points:

- the importance of **teamworking** in primary care;
- the need for practices to develop a system for **embedding audit** in their work;
- the value of **external support** for a practice's audit and development programme.

Audit and teamwork

We began by defining practice development as involving the whole primary health care team. The examples that we have chosen emphasise collaboration and multidisciplinary working and show how audit can assist many aspects of clinical and organisational development in a practice. However, we do not want to devalue the contribution audit by a single discipline can make to practice development. Indeed, most published accounts of audit in primary care have been carried out by one professional group, typically doctors, with little involvement of colleagues from other professions or patients.[19] There are aspects of the work of each professional group which are probably best reviewed independently. Prescribing, for example, has been a popular topic for audit by GPs, facilitated by the availability of PACT data and supported by advice from FHSA independent medical advisers. As a result of audit, practices are increasingly adopting policies or formularies to guide prescribing decisions. Other popular topics for exclusively medical audit are use of diagnostic tests and referral to hospital outpatient clinics. Perhaps this is because some of the most obvious problems revealed by audit can be solved by GPs alone, but for most primary care work this is not the case. Services are typically provided by several professionals working together; patient care is shared with hospital departments or community health services; and the clinical and organisational aspects of care are necessarily interdependent.

Although one discipline may initiate an audit, completing it and putting the findings into practice almost invariably involves others. Therefore, with practice development as our starting point, we have emphasised schemes which encourage participation of the whole practice team in audit and which facilitate audit of a wide range of primary care activity.

Advocates of multidisciplinary audit often argue that auditing together helps primary care teams work together more effectively in general. This may be true for established teams with a track record of collaboration, but we suspect that for teams with little experience of joint working embarking immediately on multidisciplinary audit may be a risky venture with a high chance of failure. It may be more likely to jeopardise teamwork than to enhance it. In short, if team development is the goal, audit is probably not the best place to start. Putting team building on the practice development agenda in its own right, to be pursued in parallel with aims to improve services, may be a more fruitful approach, as demonstrated by the success of the HEA's team workshops. Once the basics of teamworking are in place, practices may find it easier to adopt schemes such as the practice audit plan and to increase team participation in preparing and following through business plans, annual reports and manifestos.

Embedding audit

The examples given here also indicate that audit is most likely to make a useful contribution to the development of a practice if it is incorporated into a practice's activities in a systematic and planned way. The practice audit plan, programmes for producing an annual report and the business planning cycle all provide frameworks which link audit directly with a

practice's current work and concerns. These structured approaches to audit and practice development increase the chances that the topics chosen for attention will be highly relevant to the practice team and that audit, once started, will be followed through to completion and result in change. Moreover, because they are based on the idea of development as a continuous process, they help a practice give sustained attention to each area of work. In contrast to unstructured, piecemeal, 'hit and run' attempts at audit and development, these schemes build in monitoring that changes have been implemented properly and progress has been maintained. Thus they can help practices tackle development and audit more systematically and move towards the ideal of continuous improvement in the quality of care they provide.

External support

While good organisation and management are central to effective audit and practice development, support from outside the practice can also be a critical factor. Some form of collective organisation of audit and development activities, (as in the College of Health's *Ask the patient* pilot studies, the HEA's team workshop strategy and the TOGPOP initiative) can:

- ❑ stimulate a practice team's interest in service review and gain their commitment to change;
- ❑ facilitate exchange of ideas and comparison of practice;
- ❑ offer tried and tested methods of audit and development that emphasise agreeing where change is needed and seeing through its implementation;
- ❑ provide resources in the form of information and skills to which practices may not otherwise have access.

A particular strength of the examples we have described is that, while offering practices the benefits of participating in a specially organised initiative, they do not seek to restrict a practice's autonomy. The emphasis is on helping practice teams to define their own objectives, make realistic plans and put ideas into action at their own pace. All organisations with a stake in primary health care development, either nationally (such as the HEA or the College of Health) or locally (such as FHSAs, purchasing authorities, provider units and trusts, DHAs, CHCs, LMCs, MAAGs and university departments of primary care), could play a part in fostering practice development through this kind of approach. For them the attraction lies not only in helping individual practices raise standards of care but also in achieving their own aims for developing services.

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CHAPTER 4
SERVICE DEVELOPMENT

Service development in health care is about innovation and change, implementing proven good practice, testing new ideas and learning from attempts to improve the organisation, delivery and quality of health services. It involves checking that a service is meeting the aims of providers and matching the expectations of users, but it requires more than just ensuring that things are running smoothly. It implies a constant search for answers to the question 'how could this service be improved?', and a commitment to putting ideas into practice. Ideas may come from service providers, managers or users, from the results of published research or unpublished local studies, and from local or national policy directives. The processes of service development – setting goals and objectives, implementing change and assessing the results – require a high level of cooperation between managers and service providers, as well as the involvement of service users or their representatives. Indeed, forging new alliances and gaining cooperation may be a necessary part of the process. [1,2]

Providing a primary health care service, whether for the whole of a defined population, for a group within the population such as children or elderly people, or for those with a specific illness or condition such as diabetes or stroke, is often the responsibility of several different agencies and involves numerous practitioners from a variety of disciplines. Thus, service development in primary care typically requires collaboration between agencies, both statutory and voluntary, and between professionals caring directly for patients. The need to work across organisational and professional boundaries may create roles for 'brokers' or 'change agents'. They can take a broader view of the service than stakeholders who may be constrained by organisational loyalty, professional ideology or day-to-day responsibility for individual patients. Sometimes, specialist workers are appointed to take charge of service development projects, with a steering group to give support and management. More often initiatives are taken by planning teams and management groups, with an existing member of staff acting as broker or change agent. In primary care development there are examples of the broker role being taken by managers, public health doctors, GPs, nurses, hospital consultants and academics.

Audit and service development

The emphasis of service development is on making changes to improve delivery and quality of services. Introducing and sustaining new ways of working may take precedence over monitoring and evaluation, especially if the need for change has already been established or is assumed to be self-evident. Evaluation may be separated from development and seen as a one-off project rather than a part of a continuous process giving feedback about the effectiveness of change. However, the activities of the audit cycle are clearly compatible with the processes of development and audit is increasingly making contributions to the development of primary care services. When audit precedes the introduction of change it can provide information about current practice that helps specify problems, justify the need for improvement and indicate possible solutions. When audit is undertaken after a service development has been implemented it can assess the effects of change, fine-tune the innovation and highlight any problems that may need to be addressed. In the first case, the role of audit is to help 'set the agenda' for development; in the second, its task is to monitor the impact of change. However, this distinction may become blurred, especially if development is seen as a continuous process of minor adjustments to services rather than once-only, large-scale change. Then audit becomes part of the systematic monitoring and improvement of service quality, providing a

flow of information for managers, providers and users rather than a single, special study of specific aspects of service provision.

This chapter presents many examples illustrating the different ways in which audit and service development may be linked. We look first at how audit based on a single practice or health clinic can contribute to service development. Then we consider what can be achieved by collaboration among small groups of GPs or practices. The next category includes studies that take the service as a whole, or the population receiving a service, as the starting point and collate data from all practices involved in providing care. Finally, we discuss a different approach which links audit and service development in a continuous process. It is based on overall assessment of the quality of a service and uses critical events to involve primary care teams in auditing their own performance. The chapter concludes with a summary of our observations about audit and service development.

Single practice projects

The aims of audit carried out in one practice frequently do not go beyond personal or practice development. Equally, we suspect that the implications for local policies and services often go unrecognised by those carrying out the audit and by other stakeholders. This need not be so. The examples given here show how a well-planned audit in one practice or clinic can make a useful contribution to setting the agenda for wider developments and to assessing the effects of change. Since developments in primary care often start small, we argue that more attention should be paid to learning from single practice or single site audits and ensuring that their findings are used to design larger-scale audits and to inform plans for service development elsewhere.

Our first example, an audit of the impact of developments in a child health clinic in Greenwich, had the typically modest remit of checking that the aims of improving accessibility and increasing use of the clinic by target groups had been met. The audit demonstrated that moving the clinic to a new location improved the attendance of those mothers whom the health visitor particularly wanted to use the service (see example 4.1, *Improving attendance at a child health clinic in Greenwich*). Although, unusually, the results of this work were published, the authors saw no role for themselves in promoting the new style clinic as a blueprint for solving problems of uptake of services in other areas. Rather they emphasised that their success came from understanding users' needs and offering services that met them, and advocated an approach to change based on these principles.[3]

The value of a consumer-oriented approach to audit and improving services is also demonstrated by the success of the Highgate immunisation project in West Birmingham.[4] Audit of child health clinic services by the professionals involved led to changes in immunisation sessions which increased uptake rates dramatically. Although at first sight these examples from community child health services may seem specialised and parochial, they contain important lessons for all practitioners trying to improve the quality and effectiveness of primary care.

Another study, which did not set out to produce recommendations that could be applied more generally or immediately, was an audit by outside consultants of information handling in a group practice in mid Wales. Its primary aim was to increase the efficiency of the practice. However, the problems identified and the methodology used stimulated wider interest, notably from the Welsh Office. The same team has been commissioned to work with a range of practices to secure a more broadly based view of how current records systems can be assessed and improved.[5]

Audit in a single practice, even if the results are published, is rarely as influential as this Welsh study appears to have been. Making the link between audit and service development usually

4.1 Improving attendance at a child health clinic in Greenwich

Concern was expressed about meeting the needs of mothers and children living on a large council estate in Glyndon, a deprived area in Greenwich, south east London. This led to an initiative to relocate a weekly child health clinic from a health centre two miles away to a community centre on the estate. The aims were to make the clinic more accessible to mothers living on the estate and to increase the attendance of mothers thought 'least likely to attend' plus those who were 'of concern' to the health visitor.[3]

The new clinic began to provide a service in January 1987. Mothers did not have to travel so far, the clinic was close to local shops and schools, and it had a more informal atmosphere than the health centre. It provided a weighing service, gave mothers an opportunity to see the health visitor and clinical medical officer, and sold welfare foods. Associated with the clinic were a playgroup and facilities developed by the Glyndon Health Project, including a creche and welfare rights advice. It was a busy clinic, with an average attendance of 35 per week in 1987 and 39 in 1988.

Two years after the move an audit was carried out of clinic attendance rates of mothers with a child under one year old on the caseload of the health visitor who worked with families on the estate. Before the move, an average of ten mothers from the health visitor's caseload went to the health centre clinic each week. After the move to the community centre, average attendance rose from 13 (Jan - June 1987) to 22 (July - December 1988). The increased attendance was considered something of a success because the majority of mothers on the estate were from groups identified by research projects elsewhere as least likely to attend child health clinics.

The health visitor also divided mothers with under ones on her caseload into those who were 'of concern' to her for health reasons or because of their social circumstances (N=42) and those who were not (N=33). Examination of clinic attendance rates showed that mothers 'of concern' were no less likely to attend the clinic than mothers 'not of concern' to the health visitor.

The authors conclude that relocation of the clinic appears to have met its objectives. It has increased attendance rates of mothers considered least likely to attend and does not deter those 'of concern' to the health visitor.

requires someone to act as a champion for change, disseminating audit findings and recruiting sponsors who can stimulate action on a wider scale. Often it is GPs who, having audited their own practice and seen the need for more widespread change, become advocates or brokers in the process of developing services. The next two case studies illustrate how enthusiastic GPs, using audit results from their own practices to justify the need for change, took an active part in improving the delivery of care.

The first example, *Improving referrals to outpatient departments,* shows how audit findings can start debate about the need for change and lead to recommendations for district-wide developments, as well as generating ideas for extending services offered by a practice (see example 4.2). The results of a survey of current practice were used by the GPs as the focus for discussions with hospital consultants, which generated guidelines for referral that were then circulated to all local GPs.

4.2 Improving referrals to hospital outpatient departments

A one-year prospective audit was carried out to determine the appropriateness of referrals from a six-handed group practice to hospital outpatient departments. Information on the outcome of all referrals was sought, including the investigations carried out by the consultant that led to a diagnosis, the diagnosis reached and the management. A further aim of the audit, which was financed in part by development funds from the regional health authority, was to provide information of practical value to local GPs.[6]

During the year the practice collected information on approximately 3000 referrals and their outcomes. Lists of the referrals made to each of the 35 consultants were generated and the GPs arranged a meeting with each consultant to discuss the referral process. For each group of conditions they attempted to discover:

- how the receiving consultant perceived the appropriateness of the referral;
- what information the consultant would have liked to be included in the referral letter;
- what investigations should have been done before outpatient attendance;
- whether the GP could have managed the case better before referral.

Consultants had clear ideas of the information they required for most of the cases referred. The results of the audit confirmed that most of the conditions referred were appropriate for hospital management. However, the practice decided that 277 patients with various skin and soft tissue disorders could probably have been managed solely by the GPs. Specialist training for GPs could also have reduced referrals for cryotherapy and diabetes. For other conditions time could have been saved if the GP had supplied the consultant with results of relevant investigations.

Action taken as a result of the audit included the practice introducing a minor surgery session. From their discussions with consultants, the authors produced a handbook offering guidelines on making referrals to every specialty and setting standards for efficient referral by GPs. It was planned to distribute a copy of the handbook to all GPs in Hastings Health Authority.

In the second example, audit was used by a GP in Doncaster in 1980 to assess improvements resulting from changes in the management of patients with epilepsy in his practice. A re-audit six years later confirmed that these improvements had been maintained.[7] On the strength of these positive findings the GP then set about improving epilepsy services throughout Doncaster (see example 4.3, *Epilepsy care in Doncaster*). An earlier letter to all local GPs proposing a Doncaster-wide audit of epilepsy services had evoked widespread interest and willingness to participate. Subsequently, he realised that it would be unrealistic to expect GPs without a special interest in the subject to become sufficiently knowledgeable about epilepsy (given its relative infrequency among their patients) to improve their own services without specialist help. This view was confirmed by the responses he received to a questionnaire he circulated in 1987 to determine local GPs' views about managing epilepsy. Those who replied expressed concern about diagnosis, counselling and the use of drugs for epilepsy. He therefore set to work to create a new collaborative programme for epilepsy management in Doncaster based on specialist services from a monthly epilepsy clinic. The projected district-wide audit did not take place at that point, because he realised it was too large a commitment to undertake. Nevertheless, this example indicates how audit may act as a spur towards the development of services by clarifying both the opportunities for improvement and the nature of the change required.

4.3 Epilepsy care in Doncaster

The Doncaster project was started in 1988 on a grant from the Primary Care Development Fund. The programme of epilepsy management was based on specialist services from a monthly epilepsy clinic, staffed by a consultant neurologist, a neurological registrar, a research registrar, a community epilepsy liaison sister, a GP clinical assistant/ facilitator and a British Epilepsy Association social worker. The clinics were increased to twice monthly in 1989. There are now two fulltime specialist epilepsy liaison nurses. They and the clinical assistant are on permanent funding from the FHSA and DHA.

The clinic provides the opportunity to give greater attention to explanation, counselling, continuity of care and follow up in the community. As a result, unrecognised problems of management and coping have been identified and in many cases resolved. Methods developed include telephone links, improved cooperation cards, an epilepsy register and teaching sessions for doctors, nurses and teachers.

From the start, the intention has been to build audit into the service. All aspects of the service are documented, and a substantial database is being generated which will eventually show the size and nature of the community-based epileptic population. In collaboration with a special project team under the auspices of the MAAG, the hospital doctors and GPs have collaborated to produce 'joint guidelines for epilepsy care' and these are to form the basis for audit in local general practice.

The new epilepsy service offers considerable potential for research - a therapeutic intervention study of poorly controlled epilepsy in the community and a longitudinal study of risk factors at diagnosis which predict morbidity on treatment are both proposed. Neurological departments in other districts have expressed great interest in the service and are considering similar arrangements themselves.[7,8]

(An interview in September 1990 with Malcolm Taylor, General Practitioner in Doncaster provided information for this case study.)

One of the main strengths of 'starting small' in one practice or clinic is that audit – and change – on this scale is easier to organise, more manageable to carry out, and can produce results quite quickly compared with more extensive or ambitious schemes. The impetus for single practice audit typically comes from the interests and enthusiasm of individual GPs and practice teams, who are highly motivated to find and implement ways of improving service delivery. The time and effort they put into audit is often contributed voluntarily, so that to managers this appears to be a relatively easy and cheap way of testing ideas and plans before applying them more widely. The practices involved, however, may take a different view of the benefits and costs of audit. For example, the audit of outpatient referrals was, by the standards of the practice that carried it out, time-consuming and costly, despite the project being allocated some regional funding. There were no doubts about the rewards for the practice and the wider relevance to local services, but the authors argue that the expense to practices of this type of audit should be recognised and realistic funding provided.[6]

As so much audit in primary care is carried out in one practice or in small-scale 'pilot' developments, those responsible for both audit and service development must ensure that it yields lessons that will be of wider use. The practitioners involved need recognition, encouragement and practical support. Practical support may take the form of financial help and access to skills or resources for audit that may not be readily available at the front line of care, for example, assistance with designing the investigation, data collection and analysis, or writing up results.

Carrying out an audit in one practice makes demands on those involved. Making the connections between the findings of audit and service development is a quite different but equally demanding process, also requiring particular knowledge, skills and resources, which are scarce at the grassroots of primary care. Where single practice audit has influenced service development, someone has usually acted as a broker to promote the findings, draw out their implications and to make the necessary links with other stakeholders to begin the development process. Often it has been GPs themselves who have taken on this role but this is not the only way. Others can act as brokers, too. It is vital to recognise that the ability, status and position of the broker may be more important than the intrinsic value of the audit findings in determining the outcome of attempts at change. It is not surprising to find that brokers appear to be most influential when they have the backing of FHSAs, health authorities or other organisations that give them credibility and access to the resources necessary to make change happen on a wide scale.

We suspect that single practice audits may not have made their full contribution to service development because there has been no effective mechanism for learning from and applying their findings. This may change now that MAAGs have established their role in collating audit results, drawing out their implications and disseminating them to other stakeholders who are more directly involved in service development.

Collaborative projects

Small groups of GPs or practices often collaborate to carry out audit and the results may influence service development. In some of the examples given here audit is the only link between the practices. When practices are selected for or recruited to a study by a researcher the connection between them may be both tenuous and short-lived . GPs and practice staff may be interested in the investigation and act on the results they receive but they may have little investment in the audit findings being used on a broader front for service development. In other examples making improvements to services, not audit, is the primary aim. GPs or practices form an alliance to forge a 'corporate view' and influence provision of local services and the policies of hospital departments, health authority or FHSA. Information from collective

audit may be an important means of achieving these ends. The NHS reforms have given impetus to this kind of initiative in which non-fundholding practices join forces and use the information they hold to inform and influence purchasing authorities' priorities and decisions about service agreements. Consortia of fundholders are also being established, and some are auditing the quality of hospital services to help them monitor contracts and make decisions about what to purchase in the future.

The priority is audit – change may follow

The first two examples are of studies coordinated by research teams. The audit of health checks in three practices assessed compliance with a protocol and documented outcomes for patients after three years (see example 4.4, *Health checks in general practice*). The results have important implications for practices offering health checks, local priorities for health promotion and primary care, and national health

4.4 Health checks in general practice

In the early 1980s, the Oxford prevention of heart disease and stroke project helped general practices in Oxfordshire to introduce opportunistic health checks for their patients in order to identify those who smoke, have high blood pressure or are obese and to offer them appropriate treatment or advice. A protocol for nurses managing blood pressure was introduced, which specified annual review of patients with raised blood pressure.

An assessment of the health checks carried out in three practices in Oxfordshire was undertaken by retrospectively auditing all patients who were found to have raised blood pressure at health checks done in 1982–4.[9] The aim was to discover the extent to which these patients had been followed up, not only for blood pressure but also because of smoking habit and obesity, during the three years after their health check.

The records of 386 patients were scrutinised from the day of the health check until exactly three years later and all records of blood pressure, weight and smoking habit were noted. All 42 patients with an initial diastolic blood pressure ≥105 mmHg and 316 of 344 patients with an initial pressure of 90-104 mmHg had at least one further measurement of their blood pressure. Follow up of smoking and weight was less complete with only 50 of the 100 smokers and 67 of the 87 obese patients having any documented follow up of these risk factors. Annual follow up in the second and third years occurred in 76.8 per cent and 72.5 per cent of patients who still had raised blood pressure at the beginning of the year.

Over the three years, the proportion of patients with diastolic blood pressure ≥ 100 mmHg had fallen from 15.8 per cent to 8.1 per cent; the proportion of smokers had fallen from 26.7 per cent to 24.4 per cent; and the proportion of those who were obese from 22.5 per cent to 20.5 per cent.

The authors concluded that the audit showed that good follow up of blood pressure and possibly a reduction in the number of hypertensive patients can be achieved if enthusiasm is maintained by a nurse facilitator. However, the changes they found were modest and could not necessarily be attributed to the health checks. A randomised trial of their effectiveness is indicated. They recommend that the quality of health checks and their follow up should be improved.

policy. It is not clear how far these have been pursued by those involved in the audit.

The audit of out-of-hours GP care outlined in example 4.5 is unusual because it sought patients' views of service quality. The main recommendations concerned how practices could improve the care they offered, but the audit could also have been used to inform FHSA policies and perhaps to design further, more specific, monitoring of patient satisfaction with GP services.

An important strength of audit coordinated by academic researchers is that it is almost certainly of sound design and likely to be published and therefore made accessible to a wide audience. Thus the results are potentially influential in debates about how practice might be improved. Unfortunately, a disadvantage is the uncertain and sometimes weak relationship between academic research and service development.

The primary goal of researchers is to complete and publish their work, although many recognise their responsibility to feed back results and discuss their implications with collaborating practices. They may, however, consider it beyond their remit to open debate about their findings with managers in FHSAs or health authorities or to press for changes in practice. They may not be comfortable in the broker role: indeed, it may not be appropriate for them to take it on. Sponsors of the development that is being audited, or those funding the audit itself, may feel a greater responsibility for ensuring that the findings are used to inform service development. Collective audit coordinated by

4.5 Patients' assessments of out-of-hours care in general practice

Patients and GPs regard out-of-hours care as an important indicator of the standard of care provided by a practice. A university department of community medicine undertook a study to ascertain patients' views of recent experiences of out-of-hours care.[10] The aim was to assess whether the needs of all patients were being equally well met and to examine the acceptability of out-of-hours consultations. Thirteen north London practices associated with the department took part in the study. They recorded on a specially designed card all out-of-hours calls received from patients over a four week period. A stratified sample of 177 of those patients was subsequently interviewed at home by trained interviewers using a semi-structured schedule developed through earlier exploratory interviews with patients. They were asked to describe the process and outcome of their out-of-hours call and to assess their overall satisfaction with the encounter.

Results showed that parents calling about children were least satisfied with the consultation; those aged over 60 responded most positively. Visits from GPs were more acceptable than visits from deputising doctors for patients aged under 60; older patients were equally satisfied with either.

Although the published report of this study provides only aggregate information, results were fed back to participating practices. The authors urge practices to review management of out-of-hours calls on a regular basis, particularly calls concerning children, where conflict or misunderstanding seem most likely to occur. They also suggest ways of helping patients decide whether it is appropriate to call the doctor and ways of reducing the number of out-of-hours calls, for example by improving access to the doctor during surgery hours.

researchers is more likely to result in change if FHSAs, health authorities or other agencies with a stake in service development are involved from the outset, have a sense of ownership of the work, and a commitment to implementing its findings.

The priority is change – audit may help

The next two examples are not of audit, but of groups of GPs or practices who have formed an alliance with the aim of getting more involved in local service development (see examples 4.6 and 4.7). The groups we describe are well-established, but other 'GP forums' with a similar role have been created since the introduction of purchaser-led health care.[11] The examples are of informal, voluntary groups of GPs from a relatively small geographical area who meet to discuss common interests and problems, particularly the interface between general practice and community and hospital services. Various channels are used to make a group's views about service quality known to the purchasing authority and provider units. Sometimes groups lobby for changes in service organisation and delivery. They may collate information or carry out more formal audit exercises to back up their views and plans, but audit is not their only or main purpose. They may also have a role in testing new developments on a small scale before they are introduced more widely.

An important feature of the projects in Parkside and Sheffield is that they have help with audit from a facilitator or coordinator, who also acts as a link with management in the FHSA and DHA. These built-in brokers are essential to the success of the schemes. They ensure that information from collective audit is relevant to the concerns of the authorities and is fed into the correct channels, and therefore has the best chance of influencing developments. Supporting these kinds of local GP groups is clearly attractive to purchasing authorities because they offer a quick and easy way of gauging opinions and obtaining information about service quality that is not currently available from other sources.

Fundholding practices are also increasingly forming 'consortia' and using audit to improve quality of care for their patients. For example, the five fundholding practices in Oxfordshire have agreed some quality criteria for hospital services. They are monitoring whether the criteria are being met by asking patients to complete questionnaires about their treatment and by analysing routinely available data. The Oxfordshire consortium has also begun discussion with hospital managers and some consultants, with a view to establishing shared care protocols and reducing follow-up appointments.[16]

Growing numbers of small, local groups of GPs and practices are organising collective audit to monitor the quality of services and make an input into the development of primary health care. An important strength of these groups is that they can identify local problems as they arise and respond rapidly by collecting information and suggesting solutions. Their audits are generally not elaborate, lengthy or costly special studies: they tend to be quick and simple, have a clear and specific purpose, and are carried out within the existing resources of group members. Links with managers in FHSAs, purchasing authorities and provider units are crucial to these audits being followed through to change. Where managers recognise the value of collaboration, groups have been given help with establishing the necessary connections. Elsewhere, members of the groups themselves may have to take on the broker role.

A criticism of audit by small, self-selected groups is that their findings may not accurately reflect the quality of services as a whole because group members are not representative of general practice in the area. This may be so, but audit findings do not have to be from a representative sample of GPs to provide support for arguments about the need for change or to demonstrate the feasibility of making improvements. As we argued earlier in this chapter, audit in a single practice can make a useful contribution to service development. Moreover, groups which start small often find ways of extending themselves

and becoming more representative, thus increasing their credibility and influence. As the example from Sheffield shows, a group of enthusiasts initiating audit can stimulate interest among their colleagues and eventually broaden participation in audit and service development.

4.6 Parkside Sentinel Practice Scheme

The scheme was set up in 1987 by the departments of community medicine and general practice, with the approval of the FPC and LMC. The intention was 'to establish a collaborative network of GPs throughout South Parkside to look at health within the community and facilitate the provision of appropriate services by the health authority'.[12,13]

All GPs in the area were sent information about the initiative and 20 expressed an interest. These practices were visited by the facilitator, a public health doctor with a background in general practice who had a joint appointment with the health authority and the FPC, to seek their views about health authority services. A series of regular lunchtime meetings began in 1988 and have continued. They provide a forum for the GPs to meet one another and to discuss topics of local concern.

Issues tackled by the group include:

- Difficulties of arranging emergency admissions to local acute hospitals. To support their case, GPs logged all emergency admissions on a specially designed form and a summary of findings was prepared for health authority managers. There was little change in the organisation of admissions as a result, but managers realised the importance of GPs as a source of feedback about health authority services and now use the group as an informal sounding board.
- Access to physiotherapy services. The facilitator successfully negotiated direct access to the services of the community physiotherapy team for Sentinel Practice GPs. This pilot project is being evaluated with a view to extending the service to all local GPs.

As well as reducing the isolation of GPs in a deprived inner city area, the scheme has established informal links between local GPs and managers in the health authority. It has confirmed that GPs have a role in monitoring health authority services and can play a valuable part in testing new ideas and developments. Having a facilitator who knew the workings of inner city general practice and who had a legitimate and relatively senior position in the FHSA and health authority was essential to this scheme. In particular she was able to feed information into the appropriate channels and to indicate how problems identified by the GPs might be solved.

(An interview in November 1990 with Rosemary Beardow, Consultant in Public Health Medicine, North West Thames Regional Health Authority provided information for this case study.)

4.7 Towards Coordinated Practice

Towards Coordinated Practice (TCP) has been in existence since 1989, but grew out of an informal group of like-minded doctors who had been meeting for about ten years. It currently includes eight practices in different parts of Sheffield, which between them cover 7 per cent of the population (about 38,000 patients). A full-time coordinator is funded by the FHSA. The project explores the benefits of practices working collaboratively:

- to share information, such as PACT data, referral patterns and details of practice staffing;
- to develop the existing home birth service in Sheffield;
- to share skills, learn from each other's experience and provide mutual support;
- to provide a forum for experimentation in developing primary care services.

When the NHS reforms were introduced, TCP developed a monitoring role, assessing the quality of service their patients receive from hospitals and other providers. The aim was to use the information gathered by practices to influence and inform their purchaser (DHA) about how service agreements with providers should be developed and where they should be placed.

TCP has already undertaken a review of referrals to general medical outpatient departments, collating information from hospital letters. The intention is to concentrate initially on measures of process, such as waiting times in clinics, liaison at discharge, quality of information to patients, etc, and later to extend the approach to include GP performance and health outcomes. This scheme for monitoring quality has now been extended to include 21 practices across the city and a researcher has been appointed.

TCP believes that there is an important role for groupings of non-fundholding practices in monitoring service quality. They can gather objectives and valid information from patients and GPs, and the results can be generalised, with certain safeguards, to the whole of a district.[14,15]

Service reviews

The examples we discuss next are studies which review the performance of a service as a whole. They have explicit service development objectives and some were part of more extensive initiatives to improve service quality. They are all research projects that involved special collection and analysis of large amounts of data. Public health doctors and hospital-based specialists played a central role in setting up the studies and assessing the quality of primary and community-based care. Most of the studies had significant input from managers. In some cases there was no direct involvement of the practices or teams providing the service, although they may have been informed of the study findings. The examples can usefully be divided into two types:

- those in which audit precedes development, helping to **set the agenda for change;**
- those in which audit is undertaken been introduced, with the aim of **monitoring the impact of change.**

Setting the agenda for change

The first two examples are investigations of current practice and its problems. The study from Somerset of child development screening in general practice shows how problems with a service can be identified using audit and suggestions for change made as a result (see example 4.8). In this case the researchers attempted to take an objective view of the performance of the service and outcomes for children. Their finding that the current development screening programme was not very useful was supported by GPs' views. They concluded that change was needed, including clearer aims for the programme and better screening tests, but gave no indication of how consensus might be reached locally or improvements introduced. It is interesting to compare this study with the report from Northumberland of an audit of child health

4.8 General practice developmental screening in Somerset

All developmental screening in Somerset is performed by GPs and health visitors, who themselves decide what is to be done in each practice. The health authority pays GPs for two preschool examinations – one at six weeks and another before the child starts school. A study was set up to assess the usefulness of this system of screening. Specifically it set out to discover whether preschool screening checks were identifying children with later educational problems and picking up treatable medical conditions that would not otherwise be identified.[17]

The records of 1,504 seven year olds living in a defined area of Somerset were reviewed retrospectively. Assessment by a health visitor at age three and a half had a sensitivity of 45 per cent for identifying the 103 children with special educational needs; the sensitivity of the preschool examination by a GP was 56 per cent. There was no relationship between the results of preschool developmental assessment and later reading ability. Of the 23 children in special schools, 22 had been identified independently of the developmental screening programme before starting school. The preschool medical examination revealed fairly minor medical problems: 29 of the 81 children referred for specialist opinions were shown to be normal, and for only seven of the others was information about their medical conditions given to teachers.

The authors conclude that, in Somerset, screening children at predetermined ages has not been very useful. A survey of the 59 GPs caring for children in the study confirmed this view: 36 of the 37 who replied thought that screening revealed little that they did not already know about the child.

Suggestions for improving the effectiveness of assessing the development of preschool children include using a standardised and validated screening instrument (already introduced in Somerset), asking parents, screening opportunistically in the GP surgery, or using questionnaires. Selective review of certain groups of children may be more productive than assessments of all children.

This study was part of a review of preschool surveillance by Somerset Health Authority and the authors place a strong emphasis on defining the aims and content of the programme and being able to audit measurable items.

surveillance undertaken two years after a new policy with explicit aims had been implemented (see example 4.12).

Rather than looking at the service from one point of view, the Doncaster study of orthopaedic outpatient referrals was designed to clarify the various stakeholders' perceptions of problems with current practice (see example 4.9). Although the study was initiated by the dissatisfied hospital consultants, it was recognised that other stakeholders, i.e. patients, GPs and managers, were likely to hold different views about where problems lay and how they might be resolved. Commissioning a respected, independent academic to carry out a study to provide a detailed description of current practice and stakeholders' satisfaction with it was an important step in starting the process of development. This example is unusual because

4.9 The Doncaster study of orthopaedic outpatient referrals

The aim of this study was to identify how outpatient referrals could be improved from the point of view of GPs, consultants and patients. It was initiated by the orthopaedic consultants, who were concerned about inappropriate referrals from GPs and it was funded by the health authority. The audit was carried out in collaboration with an academic department of general practice.[18]

Information was collected on 628 consecutive new patients booked into the orthopaedic clinic over six months by sending questionnaires to GPs, consultants and the patients themselves. At the time of referral, GPs were asked about reasons for referral, how necessary the referral was, how much pressure had been applied by the patient, and whether provision of other facilities might have prevented the referral. After the patient had attended the outpatient clinic, the consultant was asked to rate the appropriateness of the referral. Patients' satisfaction was assessed immediately after they had seen the consultant, and they were given a more detailed questionnaire to complete later and return by post. Finally, GPs were sent a second questionnaire asking how useful the referral had been to GP and patient.

Results from analysis of the questionnaires highlighted important differences in the views of GPs, consultants and patients. A meeting of consultants and GPs was arranged to discuss the survey results and this helped to identify practical issues for change. Suggestions for improving the service fell into four main groups:

1. Enhancing GPs' skills in managing certain orthopaedic problems. Providing additional training and developing guidelines for referral would be important elements in this strategy.

2. Giving GPs better information about available hospital services, so they can choose the most appropriate referral pathway for their patient. This includes clarifying to which services, for example chiropody and physiotherapy, GPs can refer patients directly.

3. Changing administrative arrangements so that waiting times in clinics and other hospital departments would be reduced.

4. Improving communication between GPs and consultants. Insufficient information in letters was a source of dissatisfaction. Some GPs also wanted easier telephone access to consultants to discuss clinical problems and get advice. This has been arranged and is being evaluated.

patients' views of the service were sought in the same study as providers' views. Patient satisfaction surveys are usually conducted as a separate exercise and, as such, are a less powerful stimulus to change than studies based on information from service providers.

A research assistant was employed to collect and analyse data for this study, which added to the costs of the exercise. Any review which requires special collection of information is a relatively slow and expensive way of setting the process of service development in motion, even if the research team is efficient. Starting with an independent study may sometimes simply be a delaying tactic on the part of those who are unwilling to review their own practice and reluctant to face up to change. In these circumstances audit findings are often disputed rather than becoming, as in Doncaster, the agreed baseline from which negotiations about change can begin.

The authors of the Doncaster study themselves hint that there may be quicker and cheaper routes to the point they reached when the study was written up. More limited data collection and simple analysis could perhaps have started a similar process of meetings and discussion among providers to identify problems and find ways of resolving them. Sometimes ready made agendas for debate can be drawn from the findings of studies carried out elsewhere such as the results of deliberation by expert groups or the recommendations of national working parties. Energy and resources can then be focused on auditing specific aspects of local services.

The Doncaster study, however, had some important advantages. Participation in the review from the beginning by those providing the service may have given them a sense of ownership of the initiative and secured their commitment to making changes. It was also extremely successful at untangling the different stakeholder positions and setting out options for improving the service, some of which had already been implemented by the time the study was published.

Just as audit of current practice can be used to stimulate constructive debate among stakeholders, there are also examples of it being used confrontationally by one group of stakeholders at loggerheads with another. For example, consultant obstetricians in Bradford published the results of their audit of general practitioner obstetrics and made the case for greater control over GP participation in obstetric care.[19] They may have had good reason for 'going public', but using audit findings in this way seems more likely to exacerbate conflict and close off possibilities for change than to open up the kind of debate which leads to positive developments.

Monitoring the impact of change

The three examples from West Berkshire, Ipswich and Northumberland show how audit can be used to monitor the effects of changes in the delivery and organisation of primary care (see examples 4.10, 4.11 and 4.12). New systems of community obstetric care, shared diabetic care and child health surveillance were introduced in these districts. Audits were carried out to check on compliance with agreed guidelines or standards and to evaluate outcomes for patients, although none of the studies sought patients' views directly.

All the studies used guidelines laid down in local policies as criteria against which to audit performance. They also used outcome measures, such as immunisation rates and perinatal mortality, to evaluate the changes that had been introduced. The two schemes in West Berkshire (see example 4.10) and Northumberland (see example 4.12) were presented as success stories and made no suggestions for further improvement. Clearly a great deal of effort had gone into ensuring that the new systems were carefully and properly implemented before assessment was carried out. The results were indeed encouraging, but not all the findings were unequivocally positive. If the audits had incorporated structured surveys of GPs', health visitors' and midwives' opinions of the new systems they might have been more effective at highlighting aspects that required further attention.

4.10 Community obstetric care in West Berkshire

In 1988 a new policy for antenatal care was introduced in West Berkshire. The stimulus for change was overcrowding in hospital antenatal clinics and increased pressure on the consultant labour ward following closure of three outlying GP obstetric units. It was also recognised that the skills of GPs and midwives should be utilised more fully.

Under the new policy, all women assessed as 'low risk' received their antenatal care from GPs and community midwives. A new booking system was introduced which did not require women to attend a hospital clinic; community midwives held their own clinics; and procedures for referring women for a specialist opinion were streamlined. The consultant and GP labour wards were integrated.

In 1989 the new arrangements were evaluated by the consultant obstetricians.[20] Fifty eight per cent of the 5,372 women who had babies during the year were booked for GP care. However, almost half of these were transferred to consultant care. Thirty per cent of women received their entire obstetric care from GPs and midwives. Perinatal mortality rates compared favourably with those before the scheme was introduced. Attendance at hospital antenatal clinics fell by 16 per cent. The authors conclude that 'antenatal care of low risk pregnant women may safely be provided by their general practitioner and midwife'.

The focus of this audit of a new style antenatal service was on the safety of the care provided as indicated by measures of perinatal mortality, and on benefits to the hospital. Some anecdotal information is provided about midwives' acceptance of the new system, but the audit did not include surveys of the views of midwives, GPs or the women who had babies. Despite a high proportion of women being transferred from GP to consultant care at various stages of pregnancy and during labour, there is no suggestion that this might be a problem or require further investigation.

The audit of comprehensive shared diabetes care in Ipswich revealed some serious problems with the new scheme and the authors made general suggestions for further change to improve performance (see example 4.11). Some of these would have required substantial alterations to the way practices organised diabetic care, but the authors did not discuss how these developments might be encouraged.

In all three examples the focus is on presenting the audit findings, rather than describing how the findings might be used to push forward the process of service development and enhance patient care. This emphasis on measurement of performance rather than management of change is a recognised problem in published accounts of audit, and limits their value to others who want to improve the services they provide.[22]

4.11 Comprehensive shared diabetes care in Ipswich

In 1981 a scheme for sharing the care of diabetic patients between hospital and GP was introduced in Ipswich Health Authority. The aim was to include all general practices, provide enough flexibility to allow different methods of working, and use a computer-based system to recall patients to the hospital for screening for complications.[21]

In 1981 a series of GP postgraduate meetings was devoted to diabetes care. All 164 GPs in 42 practices were invited by letter and at least one GP from all practices except one took part. The meetings offered a general update on the essentials of diabetic care and participants defined the minimum requirements of care. There was strong interest in improving care and developing new systems. As a result, the GPs agreed to look after more of their own patients with diabetes. They undertook to provide agreed standards of care, follow up and recording, but each practice was responsible for its own system of achieving these. All patients were to be reviewed in hospital after two years.

Patients meeting certain criteria were discharged from the hospital clinic to GP care, given a cooperation book and entered on to a computerised recall register. After two years patients were recalled to the hospital clinic and examined. The care they had received from their GP was established from cooperation book entries and a questionnaire. Analysis of the first 209 patients reviewed showed some important deficiencies in the scheme.

Of these 209 patients, 117 had written entries in their cooperation books that showed assessment of their diabetes by their GPs. Ninety two had no entries. Sixty four thought their diabetes had not been checked. The cooperation book entries showed an erratic and generally poor standard of supervision: many patients had had no measurement of weight, blood pressure, urine or blood glucose, and few had had foot and eye examinations. The hospital review detected new cases of eye and foot complications and blood pressure requiring treatment.

The hospital team which carried out the audit were disappointed with the initial results of the scheme. To improve performance they suggested:

- ❑ giving better advice to patients on discharge from hospital care, together with a computer 'prompt' to patients to visit their GP for follow up;
- ❑ better organisation of diabetic care in general practice, including a register of diabetic patients in each practice, 'protected time' for care of diabetes, and greater involvement of practice nurses in organising and delivering care.

The paper does not give any indication of how these recommendations might be implemented in Ipswich.

4.12 Health surveillance of preschool children in Northumberland

In 1984, after discussions about child health surveillance between paediatricians, medical and nursing managers in the health authority and the LMC, a scheme was initiated to improve this service and enable it to be evaluated.[23] A senior registrar in community paediatrics coordinated the scheme and over period of one year discussed surveillance with every GP, health visitor and CMO in Northumberland. The aim was not to impose a uniform system of surveillance across the district, but to seek 'common ground' in each primary care team about what should be done, at what ages and by whom. As a result, some basic principles of preschool surveillance were agreed; all teams undertook to do a basic minimum set of screening tests and referral pathways after failed screening tests were clarified. The teams themselves were to decide who would do each test. Broadly, it was agreed that:

- rather than undertaking routine developmental screening, tests should be performed with a clear referral pathway for children who failed the test;
- an aide memoire of topics to discuss with parents would be provided for staff;
- training would be linked to local procedures;
- audit of the performance of primary health care teams and regular reporting back of data must be an intrinsic part of the programme.

The agreements were introduced in January 1986 and the new approach has been evaluated by the coordinator (now a consultant paediatrician).[24] A local data collection system has been set up that allows information to be reported back to primary health care teams 'at a rate and in a manner that is meaningful and flexible and, when necessary, could be tailored to meet the needs of an individual practice'.

Aggregate information about the programme showed that primary care teams were doing what they had agreed to do in 1986 and that over 90 per cent of children were included in the programme. A striking increase in immunisation uptake had occurred, the co-ordinator attributed this to feedback on performance given to primary health care teams, since comparable improvements did not happen elsewhere in the region. Other indicators of better service delivery were a continuing reduction in the age at which deafness was recognised and hearing aids fitted, and in the age at which children with cerebral palsy started physiotherapy.

The focus of this audit was on showing that the new surveillance system was associated with continuing improvements in indicators of child health. No information was included on parents', GPs', health visitors' or CMOs' assessments of the scheme. There is no discussion of how the service might be improved further.

Although all three schemes appear to have made provision for continuous monitoring of performance, only the study on health surveillance of preschool children in Northumberland reports using feedback of information to primary care teams as part of the process of development and involving teams in discussing modifications to the scheme (see example 4.12). However, all three examples show that there is potential for audit to become part of a continuous review process, reinforcing learning and change within primary health care teams, and informing and shaping service development on a wider scale.

An important strength of the examples discussed here is that they build up information about individual patients and from primary health care teams into a complete picture of service quality that allows variations in performance to be identified and investigated. This is of particular value to managers for purposes of planning and monitoring services.

Reviews and development

Service reviews usually have explicit goals in relation to service development. Some aim to demonstrate deficiencies in order to justify a proposed course of action or attain consensus among service providers on the need for change. Sometimes this kind of audit is a necessary step in the process of development, but we suspect that often there may be simpler, cheaper and faster ways of achieving the same results. Studies are also carried carried out to monitor the impact of change. Unfortunately, some published reports are disappointingly self-congratulatory: they selectively present evidence of success, without discussing difficulties in implementation or acknowledging that there may be opportunities for further improvements in services. This clearly limits the value of these reports to those who may be interested in introducing similar developments elsewhere.

The fullest contribution to service development is likely to be made by reviews which have the following features:

- ❑ Represent the views of all those with a stake in the service, as providers or users. Studies which are designed to separate out different points of view are more informative and more useful when changes are being negotiated than those which take a single perspective.

- ❑ Develop methods for continuous monitoring of performance rather than measuring quality at only one point in time;

- ❑ Provide regular feedback about performance to primary health care teams, other service providers, managers and purchasing authorities.

- ❑ Create opportunities for service providers to discuss the feedback and to use it to help make changes in the way they work.

- ❑ Bridge the gap between those at the grassroots delivering services to patients and those involved with planning and policy-making at authority level. Service reviews often seem to be a one-way process, with specialists assessing generalists or managers assessing practitioners. However, the examples suggest that collaboration is most likely to lead to effective service development. Reviews should suggest modifications to policies and plans just as often as changes in primary health care teams' ways of working.

Audit of critical events and continuous improvement of services

A system of continuous audit organised and managed by the health authority in which primary care teams participate has been established in Southern Derbyshire Health Authority (see example 4.13). It uses 'critical events' as the starting point for auditing primary and community child health services. In this case study the critical events are post-perinatal deaths (in the age group one week to one year) and the method of audit is a confidential inquiry which brings together the health and social services professionals who have been involved with the child and family. The system of confidential inquiries has been in place since 1987 and is now an accepted part of the service. Its emphasis is not on finding fault with individuals or assigning blame, but on enabling primary health care teams to improve their practice and, using information from events surrounding unexpected deaths, to identify and remedy weaknesses in child health services.

There are a number of reasons why this system has been readily accepted by primary care workers and has become an effective method of monitoring the quality of child health services. There is consensus on the importance and relevance of the events being audited. Deaths are relatively rare and mortality rates are accepted as one, albeit incomplete, outcome measure for child health services. The confidential inquiry is run along the lines of a case conference, which is a familiar and valued way of working for most participants. Its organisation and structure are formal, but with skilled facilitation the discussion can have an informality that encourages everyone to contribute. The emphasis of the inquiries and the system as a whole is on learning and change to improve services. It is not punitive and there is no attempt to find fault or apportion blame.

Management involvement in the inquiries is also a key factor. A named senior manager taking overall responsibility for the programme is considered to be essential to its success.[26] In this example the SCMO has taken on this role, which requires one session a week of her time with half a session of administrative support. To make the system work effectively requires a wide range of skills, for example chairing the case conferences and feeding back information to individuals and departments. In the case conferences the SCMO must facilitate exchange of information, deal with anxieties, and ensure that problems are acknowledged by all participants. She also acts as broker and change agent, using the information generated by the case conferences to stimulate others to alter established ways of working. This often means persuading managers in other disciplines, units and agencies that change is needed, as well as making an input into the planning and policy making processes in the health authority. Her relatively senior managerial position is important to fulfilling these roles effectively.

Finally, the way the system is managed ensures that the 'feedback loop' between practice and policy is completed. The inquiries enable managers to check that staff know and are complying with current policies, and to identify problems that may indicate that policies should be revised. The emphasis on responding rapidly to findings means that practitioners may see change happen as a direct result of an inquiry.

4.13 The Southern Derbyshire inquiry into post-perinatal deaths

In the early 1980s, the Specialist in Community Medicine (Child Health) became concerned that Southern Derbyshire's cot death rate was higher than the average for Trent region. In collaboration with Professor Emery at Sheffield University, an authority on cot death, she initiated a two-year research project to investigate and try to reduce the unacceptably high mortality rate. A system of confidential inquiries into the deaths of all children aged between one week and one year was established in 1987, modelled on a scheme pioneered in Sheffield.[25]

The new system was carefully planned and subject to wide consultation. It was approved by the LMC and the joint planning group for children's services. The inquiries are now part of mainstream child health services and are managed by a senior clinical medical officer (SCMO).

The SCMO's office is notified of all deaths in the relevant age group. For each case information is sought from the health visitor, GP, hospital in which the baby was born, hospital social work department, and hospital doctor if the child had been an inpatient or attended an Accident and Emergency (A&E) department. On the basis of this information, the coordinating doctor categorises deaths as 'expected' or 'unexpected'. Expected deaths, for example due to congenital abnormalities or extreme prematurity, are discussed by the SCMO and her community and hospital paediatric colleagues. For unexpected deaths in the community, the inquiry takes a different course. Once a copy of the child's post mortem report has been received, a community health doctor visits the child's parents at home, if they consent in writing to this meeting. Refusals are rare. The doctor asks the parents to describe in detail the circumstances surrounding their child's death, which often reveals new information. The doctor explains the post mortem results and answers the parents' questions. This is not the same as a bereavement visit, which is the responsibility of the health visitor. Nor does it replace the service provided by a hospital paediatrician who offers to see the parents of all babies dying post-perinatally.

Then a case conference is organised by the SCMO. It is held in the GP's surgery and invitations are routinely sent to the GP, health visitor and the doctor who visited the parents at home. Social workers may be invited if they have been involved with the family. The conference is chaired

by the SCMO. The aim is to lay out all the information about the death and to decide if it could have been prevented. If it was preventable, the conference identifies what could have been done, when and by whom, but does not seek to apportion blame. The system is geared to helping the team learn together and is not punitive.

Information from all the case conferences is collated by the SCMO. Where obvious problems have been identified she may take immediate action to inform others and to make necessary improvements. The information is summarised, with recommendations for change, in an annual report to the Director of Public Health.

The confidential inquiry system is now well known and valued by GPs and community health staff. Most general practices have by now been involved in an inquiry and familiarity has increased GPs' acceptance of the system. Links between community child health services and local GPs have also been strengthened as more GPs have been trained for child health surveillance following introduction of the new GP contract in 1990. Through the training programme more GPs have got to know the SCMO and have discovered the expertise and skills she has to offer.

The SCMO has found that those taking part in an inquiry are prepared to explore what happened and their role in it, and are more willing to offer opinions in discussion than in written reports. Most of what comes out of the case conferences is of relevance to the participants, in terms of raising questions about their individual practice, increasing their understanding of cot death, and improving team performance.

The case conferences have also highlighted problems of wider relevance to managing primary care and to integrating primary care and hospital services. For example, one case showed the limitations a large caseload placed on a health visitor's child protection work. Another revealed that hospital staff were giving inappropriate advice to parents of sick babies. A new policy was introduced after discussion between hospital staff and the SCMO. Examples of good practice are also sometimes highlighted by the audit of deaths, and these can also be used as a basis for recommendations to improve services.

Material from the inquiries, suitably anonymised, has been used by the SCMO in multidisciplinary training sessions in the district. As well as introducing primary care workers to a simple form of audit, this is seen as the beginning of developing standards for good practice in child health services.[26]

(An interview in December 1990 with Liz Adamson, Senior Clinical Medical Officer, Southern Derbyshire Health Authority, provided information for this case study.)

Conclusion

The examples in this chapter illustrate a wide variety of ways in which audit can contribute to the development of primary health care. Audit is just one way of starting or maintaining the process of development. It makes its main contribution by highlighting where and how improvements could be made to existing services. The examples suggest how links between audit and development could be strengthened, thus increasing the potential of audit to enhance the quality of primary health care.

Small-scale audit

Audit carried out on a small scale, (in one practice or clinic or by a group of self-selected practitioners in collaboration) often has service development implications, although service development may not be the main purpose of the audit. The examples show that individual 'audit entrepreneurs' and groups of enthusiasts can bring about improvements not only in their own work and in the services provided by their practice, but also in primary care services more generally. Of course they must be given encouragement, sufficient resources and help to make the right connections with the organisational and management networks that support service development.

Promoting small-scale audit should have many attractions for managers in health authorities and FHSAs. Audit findings can be used to stimulate and influence debate about the need for change. With audit built in from the outset, demonstration projects can test and refine new ways of working before they are implemented more widely. Small-scale audit is easier to organise and therefore often produces results more cheaply and quickly than a full-scale study, although to the practitioners involved the costs can sometimes seem unacceptably high. It has the added benefit that the participants are highly motivated to see the audit through to completion. However, it is precisely because participants are self-selected and enthusiastic that questions may be raised about how representative they are and whether audit findings from their practices can be generalised to others.

Brokers, facilitators and champions of change in their many different guises are essential to publicising and implementing the results of small-scale audit. They can point out the implications for service development and make the necessary links with those who can use the findings to influence policies, plans and practice. Practitioners and academic researchers who have carried out an audit sometimes take on the broker role themselves, and our examples show that they can play a key part in local service development initiatives. What we do not know is how often self-appointed brokers of this sort are successful. The examples suggest that their influence is greatest when they have gained the backing of health authorities and FHSAs. Schemes with a 'built-in' broker leave less to chance. Someone is appointed to promote collaboration between local practitioners and to establish 'vertical' links between grassroots audit networks and the agencies with a stake in service development. These schemes increase the likelihood that topics selected for audit by practices are relevant to local development agendas. Consequently, service development agencies may be more willing to invest in audit and to act on its results. The schemes also enable information to be fed into the correct channels, thus increasing the chances of influencing decision making.

Current government policies, which view audit as an enterprise for individual GPs, are likely to encourage small-scale audit. The danger is that the result will be 'confetti audit', i.e. a plethora of small, scattered, one-off investigations that do not add up to much and are wasteful of resources. The challenge is to keep the focus of audit in primary health care at the grassroots where patients receive clinical care, while finding ways to increase its impact on the organisation and management of services. Schemes to coordinate small-scale audit show that it is possible to do this and to

use resources efficiently. In addition these planned and proactive approaches to audit preserve the autonomy of the primary care workers involved and do not appear to diminish the diversity of topics chosen for audit.

Larger-scale audit

Service reviews are a method of audit widely used in health authorities and are a well-established part of service development. They usually have management involvement from the outset and explicit development objectives. These objectives are typically to document current practice and to begin debate about the need for change or to monitor whether a service is meeting previously agreed standards. Audit of a service is particularly useful if it can be designed to reflect the views of all those involved in providing and using the service, rather than making assessments from a single perspective. Audit can be a powerful tool for bringing about change when it measures variations in performance, gives feedback to individual providers and encourages comparison of results and discussion of how improvements could be made. Again, facilitators and brokers have important roles to play in these processes.

Reviews which are both comprehensive and enable a high level of participation by primary care workers are complex to establish and can be expensive to complete. If the aim is to stimulate debate, then there may be quicker and cheaper ways of getting stakeholders round a table than launching a full-scale service review. We have argued that well-designed small-scale audit can give sufficient information to begin discussions about the strengths of a service and its problems but it may not have the scope to encompass all points of view. A ready-made agenda for debate can often be drawn from the findings of reviews carried out elsewhere such as the results of deliberation by expert groups or the recommendations of national working parties. However, if it is necessary to capture stakeholders' interest in the first place, detailed, up to date information about the quality of the service they provide is likely to be more compelling. Getting stakeholders to participate in an audit of their own may also have important advantages later in the process of service development. Audit should provide specific information about performance that cannot be disputed: problems must be faced and solutions found. Taking part in audit and discussion of its findings can secure a commitment to making change.

Comprehensive service reviews can also play an important role in assessing the impact of change. They can be a particularly effective part of the development process if, as well as giving primary care workers feedback and helping them to use it to improve their day-to-day practice, they also provide managers with information on whether standards and targets are being met. Some examples given in this chapter show how audit can identify problems in the organisation and management of a service and reveal the need for revision of policies and plans.

Some of the reviews we have described have been carried out as part of the process of establishing a system for continuous monitoring of a service. They aim to build audit into the service, making it an accepted and integral part of the way care is delivered, managed and planned. Used in this way, audit can provide a continuous stream of information about service quality for practitioners, managers, purchasing agencies and the public. The example from Southern Derbyshire shows how a simple form of audit can be used to create a culture that reinforces learning and change at all levels in a service. A considerable effort may be required to get audit embedded in a service in this way, but the rewards in terms of stimulating and sustaining development appear to be substantial. This is in contrast to those from one-off special studies which may make only a temporary impact. The Southern Derbyshire example gives important clues about how to forge stronger and more permanent links between audit and development. It also offers a vision of how we might move closer to the ideal of continuous improvement in the quality of primary health care.

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CHAPTER 5
AUDIT AND DEVELOPMENT IN PRIMARY CARE

In this book we have looked at how audit may be used productively in primary care. We have explored opportunites for using audit across the whole spectrum of development, from the solution of modest individual problems to the introduction and evaluation of service-wide improvements in care. Our aim in taking such a wide perspective has been to promote the broadest possible view of what can be done with audit. Our intention is to ensure that people involved in planning, resourcing and undertaking audit at every level are alert to the diverse uses of their chosen tool. At the same time we hope to encourage those with a more general commitment to developing services and enhancing the quality of care to recognise the opportunities for using audit constructively in their work. In this concluding chapter we draw together some of the themes from preceding chapters and go on to consider the prospects for audit as part of a wider movement concerned with enhancing quality in primary care.

In Chapter 1 we looked at audit as an innovation, the obstacles to introducing it and how they could be overcome. We considered how to ensure that audit is seen as relevant, acceptable and desirable in principle; how to make it practicable and worthwhile in practice; and how to improve the chances of carrying it through to a successful conclusion. The main responsibility for getting audit off the ground in primary care lies with the MAAGs. In the short term their task is to ensure that practitioners gain experience in doing audit and learn to make informed choices about when and how to use audit effectively. Tactics such as those we described have already been adopted by many MAAGs, and we are confident that they will succeed in engaging the majority of practices in audit of some kind. As MAAGs around the country submit their annual reports to their FHSAs, we anticipate that evidence of such progress will be forthcoming in many districts.

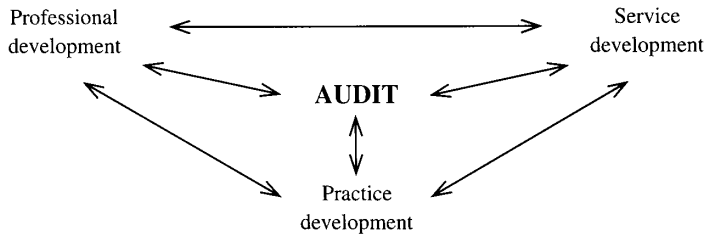
The role of audit

In the longer term audit must be seen as more than an end in its own right. It is, rather, a means to an end; it is part of the process of enhancing the quality of care. The fundamental issue for individuals, practices, MAAGs, FHSAs and other agencies is to decide what they are seeking to achieve. Whether and how audit can help them get there is one of the questions they then need to ask. In Chapters 2, 3 and 4 we explored the question of how audit might fruitfully contribute towards a wide variety of development objectives in primary care. We looked at the relationship between audit and development at three different levels: individual professional development; development of the services provided by a practice or health clinic; and development of services for a population.

At all levels we found examples confirming our view that audit can make a valuable contribution. In some cases audit provides a link between developments at different levels. For instance, an individual GP audit can lead to the introduction of a new district service; collectively organised schemes for practice development can stimulate the interest of practices in service review. It is also clear that the relationship between audit and development is reciprocal rather than unidirectional (see Figure 5.1). Many of the development activities discussed, particularly those relating to the work of the practice team, in themselves strengthen the ground for audit and open up new opportunities for its use.

The fact that we found so many positive examples at a time when audit was still a minority pursuit, encourages us to be optimistic about

Figure 5.1. The links between audit and development in primary care



the future. At the same time, it is important not to overestimate the significance of the part audit is presently playing in primary care development. Many of the examples we have given are unique. They have not been replicated in other practices or districts, nor have they been translated from one service to another. Many of them exist simply because an enterprising individual saw the development potential of audit and took the initiative to follow it through. Using audit to stimulate and fuel development is certainly not, as yet, the norm.

Making audit count

Our choice of examples is highly selective and we must therefore be careful about drawing conclusions from them. Nevertheless, it is possible to identify some of the changes which will need to occur if the potential contribution of audit to improving the quality of care at all levels is to be fulfilled.

Establishing routines

Audit must become more effectively integrated into the work of individual practitioners, practice teams and the routine management of services. At present, much audit is done on a piecemeal basis. Topics are selected for audit and information is gathered and analysed, but then attention moves quickly on to something else. This 'hit and run' approach limits the contribution that audit can make to development. Frequently, insufficient time and effort go into discussing the findings, devising ways of improving care and putting changes into practice, let alone repeating the audit to check that improvements have indeed resulted and been maintained. More systematic and planned approaches to audit, based on a model of continuous improvement of practice, offer a means of overcoming these problems. They emphasise completing the audit cycle and encourage monitoring of progress, thus reinforcing the connections between audit and development.

Working together

Collaborative and multidisciplinary audit must become far more frequent if audit is to play a more significant role in development. Currently, most audit in primary care is done by members of a single profession working in isolation from colleagues in other disciplines. Multidisciplinary networks of practitioners with common clinical interests or service commitments should become the basis for collaborative clinical audit. Stronger links must also be forged between all those sharing similar development aims. These may include MAAGs, FHSAs, purchasing authorities,

provider units, CHCs, local authority services and the voluntary sector. If all those with a stake in the development are involved from the start, the chances of bringing about change successfully are undoubtedly increased.

We found some good examples of genuine multidisciplinary work in which the views of all professional stakeholders were represented and taken into account throughout the audit cycle. However, these examples are substantially outnumbered at present by audit projects which reflect one specific viewpoint. We were less successful in finding evidence of active involvement of patients as stakeholders. Patients are currently seen as a legitimate and sometimes convenient source of information about quality of care, but are rarely consulted about which aspects of care should be audited, what changes are needed or how they might best be implemented. Patients must become more equal partners in audit and development if improved patient care is a serious objective.

Making links

Better connections must be made between grassroots audit activities involving those who provide care directly to patients, and planning and policymaking at authority level. Understandably, people tend to concentrate on issues relating most closely to their own needs. In consequence, however, the wider implications of their work are often missed. Opportunities for the results of individual audits to contribute to the organisation and management of services and development of local policies go past unrecognised. In the reverse direction, service reviews are frequently carried out from above without involving those most directly involved in providing care. Establishing and reinforcing vertical links between practitioners, managers and policymakers will make it more likely that audit is perceived as relevant by all parties and that the findings from audit are used appropriately.

Sharing experience

Audit must become a more publicly acknowledged and documented part of primary care. At a national level, several organisations including the RCGP and the King's Fund Centre provide audit information services and helplines. Most of the relevant medical journals now regularly publish articles on audit. Locally, some MAAGs are strongly committed to providing documentary resources and opportunities for exchanging information about audit projects. Nevertheless, there is still a need for more systematic and accessible information about what people are doing and what they have learned, both within and beyond the aegis of local general practice, to raise awareness of the possibilities and avoid unnecessary duplication of effort.

Facilitating change

To achieve all this, more help is needed. Examples given earlier in the book show the value of input from many different kinds of facilitators, coordinators, brokers and development workers in disseminating information, reducing isolation and increasing collaboration, especially across professional and organisational boundaries. The importance of the broker role in making effective links between audit and development needs to be more widely recognised. In many of the examples we have cited, individuals taking a broker role can be identified. However, their success has often depended on personal commitment or fortuitous combinations of roles (such as GP tutor, MAAG member and clinical assistant) which widen the scope of their influence. Organised audit schemes designed with built in brokerage are clearly in a stronger position to achieve change, since their impact does not depend so much on chance.

Looking into the future

If movement occurs on all these fronts, the impact of audit will grow and it will play a major part in enhancing the quality of services in primary care. If nothing changes in these respects, the general effects of audit will remain patchy and parochial. What, then, are the prospects of moving forward?

Any attempt to map out a potential future for audit must take account of the broad and swiftly changing context in which it exists. Looking at the wider picture, it is quickly apparent that audit is part of something bigger than itself. The 1989 White Paper initiative on audit was a major step along the path towards greater accountability and assessment of quality in the NHS, but it would be a mistake to see it as *the* major step. It signified neither the beginning of this change nor, in all likelihood, the end.

Well before 1989, major audit projects were already bearing fruit in different sectors of the health service. For example, at a national level there were the confidential enquiries such as CEPOD (confidential enquiry into perioperative deaths). Service indicators based on routinely available data were generating information for comparison of services throughout the country. In primary care the PACT system was introduced, whereby data about all GPs' prescribing behaviour is collected by the Prescription Pricing Authority and sent routinely to the FHSAs for analysis of 'high cost' practices and negotiation with GPs. In general practice there were the pioneering activities of the RCGP, such as the Quality Initiative of the early 1980s. A further development in recent years has been the involvement of the Audit Commission in assessing health service practice, thereby extending its remit beyond the local authority functions with which it was initially concerned. The quality 'movement' shows no sign yet of standing still.[1,2] Even while audit is still getting off the ground, the debate has already moved on towards grander, more thoroughgoing concepts such as Total Quality Management (TQM).[3] So whatever happens to the present audit initiative, the general concern with quality assurance seems likely to endure.

Views of audit are inevitably bound up with the other developments that have taken place. For example, uncertainty about whether it is to be used for internal or external scrutiny reflects its dual origins from two quite different sources – the internal pursuit of professional excellence and the development of external monitoring and managerial accountability. It has been argued that the success of the audit initiative depends on rejecting the traditional, punitive 'bad apple' approach to monitoring and evaluation, which aims to root out and deal with the elements causing trouble. Instead, the far more conciliatory and constructive model of continuous improvement should be embraced. This approach avoids assigning blame, emphasises the system rather than the individual, and returns the responsibility for quality to the people doing the work.[4,5,6] At present it is unclear whether widespread adoption of the new rhetoric is matched by a more fundamental change in attitudes. But if such a shift occurs, this will certainly weaken the distinction between internal and external scrutiny and alleviate some of the anxieties about confusing the two.

Another legacy of the dual inheritance is the continuing tension between attempts to harness audit as a systematic tool for planning and monitoring services and its more educational, informal and ad hoc use – the confetti model of audit. However, the relationship between the personal and professional concerns of practitioners in primary health care and the preoccupations of those involved in service management and planning is in a state of flux. The organisational changes in the NHS have brought new roles and responsibilities on both sides. Relationships between purchasers and providers of care are being redefined; fundholding practices are increasing in number and fundholding consortia are being created; points of contact between practices and FHSAs are growing through negotiation over annual reports, the mediation of the independent medical adviser, and the actions of the MAAGs themselves; and the internal organisation of general practice is changing with the development of business plans and an increased concern with practice management. It seems possible that these changes will bring about an increased awareness of areas of mutual concern and recognition of the need for cooperative and collaborative working.

Conclusion

We believe these are grounds for some optimism. Given the current pace of change in the health service, an increasing general concern with quality, and the tendency to supplant old terminology with new, the audit initiative is unlikely to continue exactly as presently conceived. Many people think that disposing of the term 'audit' would be a major step forward in itself, though it is not yet obvious what form of words might be preferred. In our view, the current MAAG structure, with its heavy emphasis on professional medical leadership, needs to be modified to take account of the wider constituency of interests in primary care. In some districts this has already happened by co-option. Equally, the remit of MAAGs should be enlarged to encompass broader development objectives, and links with the development functions of other agencies need reinforcing. These changes may lead to the groups being renamed.

There will be a continuing need for clarification and separation between monitoring for management purposes and intiatives concerned with continuous quality improvement. A balance must be achieved between providing scope for individuals to pursue their own ideas and the need to agree priorities and carry out collaborative tasks. It is to be hoped that increasing familiarity over time, the identification of common interests and an awareness of the complementarity of different development goals will provide a basis of trust on which these issues may be decided through constructive negotiation. Although not yet formally evaluated, the visible achievements of some MAAGs in their first two years have already demonstrated their value. If these achievements can be built upon in the ways described, then we are confident that such groups will play an increasingly important role in contributing to development and thereby enhancing the quality of primary care. Both audit and MAAGs may become outmoded terms, but the principles and opportunities they represent should be here to stay.

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Audit and Development in Primary Care describes how audit can be made effective. Drawing on the experience of people who have been involved in organising audit in primary care, it suggests how medical audit advisory groups (MAAGs) could help all practitioners to take part in relevant and worthwhile audit.

With the help of lively and succinct examples, the authors show how audit can help in the development of primary care, from solving modest individual problems to implementing and evaluating service-wide changes in care. They recommend changes in the way audit is carried out to increase its impact on the quality of primary care.

Audit and Development in Primary Care concludes with a positive assessment of the future for audit as part of the wider concern for quality and accountability in health care.

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