LETTERS

Routine data: a resource for clinical audit?

The recent review by Martin McKee¹ makes several important points but also raises one issue which needs further discussion. This concerns the definition of "routinely collected data" which he proposes: "data whose primary reason for collection is other than audit." It is implicit in the paper that the definition refers to data which are collected regularly and over an extended period. However, omitting these concepts from the definition leaves them unqualified. For example, would a system which regularly gathered data on, say, 10% of patients count as routine, or is this definition limited to systems covering all patients? Similarly, how long need the period of collection be: should it be open ended or does the definition include systems planned to collect data for only one or two years?

There is a more serious confusion which arises from this definition. It leads to systems such as the Lothian² and North West Thames³ surgical audits, which have collected data on every patient seen for an extended period, being described as "non-routine." The problem arises because "routine data collection" is defined in terms which do not relate to the way in which the data are collected but only to the reasons for their collection – that is, data which were initially collected for reasons other than audit. As such the definition does not follow the convention of "describing a thing by its properties"⁴ but uses instead the motives of the unseen planners of data gathering. What happens when, as is often the case with large scale data collection systems, there is more than one motive behind the data gathering: how do we decide which is the primary one? Equally, what if several people with different motives are involved in the design of the system: whose motive is to be considered paramount?

A further distinction needs to be made about the reasons for data collection, that of ownership. For some systems, such as those in pathology or pharmacy, data are requested, processed, and used by the health professionals involved in their collection. However, for other systems, such as the Körner minimum data set or cancer registry returns, data are provided by health care professionals for official purposes. Thus the purpose for which data are collected is more complex than simply whether they are to be used for audit. There is a need for a standard definition which covers all dimensions of routine data: purpose of collection, ownership, and the features of the collection process.

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- 1 McKee M. Routine data: a resource for clinical audit? *Quality in Health Care* 1993; 2:104–11.
- 2 Gruer R, Gordon DS, Gunn AA, Ruckley CV. Audit of surgical audit. *Lancet* 1986;i:23–6.
- 3 Black NA. A regional computerised surgical audit project. *Qual Assur Health Care* 1990;2:263–70.
- 4 Chambers *Twentieth Century Dictionary*. Edinburgh: Constable, 1973.

AUTHOR'S REPLY

The comments by Iain Crombie and Huw Davies are a useful contribution to consideration of the use of large data sets. The definition that I chose was designed to draw some sort of boundary around what would otherwise have been an enormous topic that would have justified a book rather than a review article. The article was aimed at those who are attempting to use administrative data in audit and not the custodians of large data sets that are now routinely collected specifically for audit, on the assumption that the latter group will be aware of most of the issues raised and will have taken steps to overcome the problems that were identified. I agree that a better definition is needed, and Crombie and Davies illustrate the complexity involved in achieving one.

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Public health medicine and public health dentistry information resource

Many public health physicians are keen to improve the quality of their work through audit. However, their efforts are being restricted by the lack of dissemination of information about audit within the specialty.^{1,2} This had led to the situation in which many audit groups are working inefficiently because they are isolated, tackling the same problems and reinventing the same wheels.

In response to this a database of published and unpublished examples of audit in public health medicine and public health dentistry has been set up by the South East Thames Public Health Medicine Audit Project. Gathered over three years, the collection has been described as "one of the foremost collections" of public health audit information in Britain.³

The database is now being made available as a national resource in the hope that it will make a significant contribution to the dissemination of information and, as a result, to the development of audit within this challenging and important field.

Contributions to the database are very welcome, particularly accounts of public health audits, standards, proformas,

checklists, and so on. Requests for information and inquiries about the database should be addressed to me (or Kay Pennick).

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- 1 Bhopal RS, Thomson RG, White M, Watson A. Audit of public health medicine: the Northern region's approach. *J Public Health Med* 1993;15:255–62.
- 2 Jacobs RE. Help on the horizon. *Public Health Physician* 1993;4:11–12.
- 3 Richman A. *The Kent Public Health Medicine Audit Project – an evaluation*. Brighton: University of Brighton, 1992:8.

BOOK REVIEWS

Audit in Mental Health Services. Jenny Firth-Cozens (pp 83; £9.95). Hove: Laurence Erlbaum Associates, 1993. ISBN 0-86377-311-7.

Mental health is widely believed (not least from within) to be an area of almost insuperable difficulty for investigations such as clinical audit, which rely on measurement and standards. The perceived problems arise from three main assumptions: that it is uniquely difficult to quantify parameters of mental health, that there are particular problems of attribution to service interventions because of the uncertain but probably multifactorial causes of most mental illnesses, and that patients with mental illness cannot be relied on as a source of self report. The effect of these beliefs can be to inhibit audit altogether or to arrest it at the stage of case review and prevent any read across from experience in other areas of health. None of the underlying assumptions really stands up to examination. There is now a range of standardised psychological rating scales of demonstrated validity and reliability; multifactorial causation is the rule rather than the exception for all states of health and illness; and, on topics other than their purely personal preoccupations, the views of mentally ill people reassuringly resemble those of people with chronic physical disorders. Some areas of mental health, notably behavioural psychotherapy, already make extensive use of measurement and rating in routine practice. There are many similarities between mental disorders and conditions such as diabetes, cancer, or chronic physical pain which should allow mental health practitioners to share the audit methodology and experience of their colleagues in these areas.

The benefit of a text such as this may be as much in the implicit message of the title – that mental health services are appropriately included in the general

requirement to audit – as in any of the detailed points of advice Jenny Firth-Cozens offers on how to do it. Her book attempts two separate tasks and succeeds to some extent with each of them. It is a source of ideas and exercises for anyone who might have to organise training events around audit. It is also an elementary text for those setting out to do audit for themselves. Although the title aims itself at mental health practitioners and examples are mostly drawn from mental health services, the principles illustrated are much more generally applicable.

I found myself nodding in agreement at the identified common ground of methodology, statistical analysis, and publishability which good audit shares with good research. I was pulled up short in several places by statements which were either inaccurate or too sweeping in their generalisation. One of these was just a minor annoyance – repeated references to the use of “Kohner” (sic) data suggests that in some quarters Mrs Edith Körner has already been consigned to the ragbag of misremembered history. Others were more fundamental and left me wondering if I (or the author) really did know what she was talking about. The categorical statement of the “golden rule” that “you can never audit anyone else’s practice” led me to expect that the author must be intending to ignore or dismiss the technique of peer review. But no, a few pages later she is quoting approvingly a national example of the benefits of psychiatrists auditing each other’s practice.

By the end I had warmed to the author’s obvious enthusiasm for her subject. It encourages the view that the limited progress so far made with audit in many mental health services is not because it has been tried and found impossible but, rather, found difficult and not tried.

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Outcome Funding: A New Approach to Public Sector Grantmaking. (UK Edition). Harold S Williams, Arthur Y Webb (pp 205; £7.95). New York: Rensselaerville Institute, 1992. ISBN 09629798-1-3. Available through the National Council of Voluntary Organisations (NCVO) Publications.

Value for money and achieving results seem to be the new watchwords for decision makers when it comes to the use of public money. But few systems exist to help decision makers focus on these aims. *Outcome Funding*, the brainchild of the Rensselaerville Institute of New York, offers a refreshing perspective.

Its approach transfers some of the main principles of the business plan used in private industry into the grant process or purchasing decisions for public money. It invites grant makers or purchasers to view themselves as investors looking for a return on their investment rather than people who just give out money.

As investors, those involved in using public money need to address three key questions: What results do we seek? What are the chances of achieving them? Are we paying the lowest reasonable cost for the best results? By use of a business plan rather than a traditional proposal these key questions are more easily addressed, compared, and evaluated. Purchasers can identify those projects which are “sure bets” and those which are high risk. Having a mixed portfolio of low risk and high risk projects may offer purchasers the best opportunity of achieving a reasonable return on their investment, of encouraging innovation and of learning at the same time.

As in the world of investment and venture capital, the business plan is seen as important, but even more important is the person who will carry out that plan. *Outcome Funding* invites public service purchasers to recognise that people are more important than paper. Knowing who is going to perform the work of the project and what makes them the best individual to invest in can go further towards securing the success of the project than any written plan.

Applying the principles set out in *Outcome Funding* can reduce the time spent in screening submissions and enable a lot more relevant information to be obtained. Using telephone interviews to talk with a potential grant recipient, breaking with traditional procedures of reliance on what is written, allows clarification, further information to be obtained, and negotiation to find the right investment for a partnership – that is, one which will lead to results mutually understood and agreed both by the purchaser and the service provider.

If the book has a fault it is that it makes too many assumptions that the funding process in the UK is fairly similar to that in the US, which is not my direct personal experience of both systems. Although the UK edition has been edited by Peter Mason, an NHS manager, it still does not reflect a full understanding of the UK system.

Demonstration projects in the public sector are now being established both in the health service and in local authorities using *Outcome Funding*. Emerging projects in London, Trent region, and Wales involve areas such as training, prevention of HIV infection, alcohol misuse, and drug treatment.

The book encourages purchasers to try outcome funding on a small scale. This experimentation can help both purchasers and the selected service providers to understand the radical shift in working practice. The demonstration can then open discussions with other providers and lead to shifts in other ways of working. As in so many other examples, it is not policy that sets good practice, it is good practice which sets policy.

Outcome Funding is easy to read and thought provoking. Much of it seems common sense. But on reflection, you quickly realise how little of it is in practice today. If this book can simply open people’s minds and introduce them to a new way of working it will have achieved a miracle.

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Specialty Medical Audit. Shaw C. (206 pp; £9.50). London: King’s Fund Centre, 1992. ISBN 0-85717-020-2.

The publication of a guide to specialty medical audit is timely but unfortunately is being overtaken by events. Although medical audit is now established as part of the normal educational activity of hospital doctors and general practitioners, its future is threatened by loss of initial enthusiasm and dilution of resources into clinical audit.

If medical audit is regarded as a useful activity the need to maintain the interest and commitment of hospital senior and junior staff has proved to be a major obstacle. Involving junior doctors in small short term projects and their senior colleagues in giving up valuable clinical time for what may not seem to be a productive activity has led to some cynicism about the audit process in general.

Specialty Medical Audit, written by an acknowledged authority on the subject, tends to draw together the experience of audit in various specialties and contains within each section some useful lists of audit topics which could be considered in a local environment and also summarises the national programmes which are evolving. By its very nature, this book is unable to be a comprehensive guide and tends to be somewhat repetitive.

Enthusiasm for the audit process is, and will remain, variable, depending on the interests of the clinicians involved, the time available for audit to be conducted, and the perceived value of the audit process. Quite reasonably, at a time of extreme financial stringency in the service, questions are being asked about the benefit to patients of medical audit. The time is rapidly approaching when critical objective evaluation will have to be undertaken before audit loses its credibility as an aid to patient care. In addition, the efforts that have been made to integrate audit into postgraduate medical education can only be dissipated by the expansion of audit, quite rightly, to include all staff.

The publication of this small handbook on specialty medical audit is therefore timely in that the detail provided on audit in various subspecialties of medicine should prevent local audit committees reinventing the wheel. However, experienced audit committee chairmen will have a feeling of déjà vu on flicking through the contents because so many of the audit projects described have been carried out in their own hospital.

Unfortunately, this is not an easy book to read and perhaps should be used as a reference manual, primarily for audit staff. New initiatives on comparative data and the need for audit departments to demonstrate cost effectiveness also mitigate against its usefulness. However, for the audit newcomer there are particularly useful chapters on how to establish and organise audit within a general hospital. Future similar publications may include chapters on how to defend the audit budget from other equally deserving demands. Although there is little doubt that the future for audit is not particularly bleak, it will be rather different.

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