Forty Practical Audit Examples – A Review. Houghton G, Sproston B (pp 90; £10). Birmingham: Birmingham Medical Audit Advisory Group, 1993. ISBN 0-9521895-0-X.

This report from Birmingham Medical Audit Advisory Group (MAAG) describes forty audit projects carried out in local practices during 1992 and 1993, funded by the family health services authority from a special allocation of development money. All practices were invited to apply for support, but special consideration was given to certain applications – for example, those constituting the first formal audit in a practice or which addressed local health priorities, requests from singlehanded practitioners, and so on. Not surprisingly, therefore, most of the projects deal with management of chronic disease and health promotion topics; 21 of the 40 are “first time” audits (including six from singlehanded practices). The results are presented in a standardised format which makes the reading less heavy going than it might otherwise have been. A description of the practice, whether a first audit, which team member led the project and the time taken (appropriately depicted in £ symbols) are followed by background details, standards and targets, methods and results, and conclusions which usually contain proposals for change. The report’s compilers (the MAAG chairman and coordinator) also provide introductory notes containing information about the initiative itself and useful overviews of each of the sections with some audit theory.

This is an interesting document, which highlights several topical issues. The large proportion of first time audits, and fairly basic ones at that, suggests that we have some way to go yet before systematic audit is “embedded” in everyday practice. Nevertheless, the fact that inner city practices, at a time of change, are inspired enough to undertake even a simple audit is a credit to their professionalism and to the efforts of the MAAG. Money talks, of course, and documentation of the amount of time and resources used in audit, as in this report, is a good idea which should perhaps be picked up by other MAAGs as it will draw management’s attention to the fact that quality does not come cheaply. The fact that several of the projects were initiated by non-doctors, and usually involved other team members, demonstrates how even the most basic audit in general practice is a multidisciplinary enterprise.

JOHN SPENCER
Lecturer in Primary Health Care

MEETINGS REPORT

**Medical Audit Advisory Group,
Birmingham, October 1993**

Is there life after audit? More appropriately perhaps, what is the future of audit

in primary care after June 1994, when the current Department of Health circular setting up MAAGs runs out? This question and the future direction of MAAG activities focused the attention of over 200 delegates representing 70% of MAAGs.

This was a timely conference, considering that MAAGs around the country are currently negotiating for budgets that will enable them to build on the achievements of the past three years. The main theme of the conference was to consider how those outside MAAGs view the development of clinical audit in primary care. The presentations focused on the progress of audit to date and the difficulties, successes, and challenges ahead.

Rosemary Field of the NHS Management Executive praised MAAGs for the way in which they had organised themselves and for winning the support and trust of colleagues. She identified three particular achievements: the development in primary care of a culture of review, improvements in quality of care, and service development. Graham Butland, general manager of Essex Family Health Services Authority balanced these successes by reminding delegates that audit had no divine right to resources, it must now demonstrate added value in order to secure resources. But he did acknowledge that with an ever increasing workload in general practice, audit needs investment, if it is not to be a piecemeal activity.

The theme of accountability was taken further by Tim Van Zwanenberg, who emphasised the need for MAAGs to have a costed business plan based on clear objectives, with effectiveness related to the achievement of objectives. The challenges are clear, audit must now be a focused activity. Attention needs to be given to audit across the interface, along with emphasis on multidisciplinary audit. Management priorities must be considered, and patient involvement, emphasised in the patient’s charter, must play a key part. As Oliver Samuel, for the Royal College of General Practitioners, remarked, “The era of gentle encouragement to audit should now be replaced by required accountability and accreditation.” This relies on committed and creative MAAGs, who because of increasing workload rely more on audit support staff. Jane Riddell outlined the work of the NHS Training Directorate in identifying the learning needs of audit staff, launching the *Directory of Available Training for Audit Support Staff*.

Audit has moved on and is now part of a larger agenda on quality. It is important that achievements are not lost but built upon to encourage a culture of continuous quality improvement among all primary health care workers.

The overall message was clear and explicit: you have done well, but there remains much to be done.

LIZ CARROLL
Audit Facilitator
JEAN SIMPSON
Regional Audit Coordinator

COMMENT

Evaluating Audit: A Review of Initiatives. Walshe K, Coles J (pp 66; £7.50). London: CASPE Research, 1993.

Evaluating Audit: Developing a Framework. Walshe K, Coles J (pp 66; £7.50). London: CASPE Research, 1993.

The two reports are intended to be read as a pair, although the review of current evaluation initiatives is an easier, more enjoyable, armchair read than its companion; readers will most definitely have to get their brain into gear if they are to follow the authors’ arguments and analytical processes in the more generic report *Developing a Framework*.

The reports are derived from the first stage of CASPE’s work, commissioned by the Department of Health, to evaluate the medical audit programme in hospital and community health services in England, which has the potential to be the most authoritative study yet. In the first report an amazing number of other evaluation projects – over 20 – have been identified, each carefully dissected to provide a fascinating and informed insight to the current state of medical audit. The results compare structures, processes, and outcomes of audit projects and programmes from a variety of perspectives, and identify the areas remaining to be evaluated.

The second report, *Developing a Framework*, dissects the meaning, rationale, and methods of evaluation applicable to health care and quality improvement programmes. The chapter on improving quality and health care provides a succinct and authoritative review of the difficulties of definition faced by the evaluator. The definitions of quality quoted confirm the barriers to “measuring quality,” as they require measurement of risks and benefits or knowledge of “best outcome,” where certainty and consensus are seldom found.

Readers might take issue with the authors’ conclusion that the structure-process-outcome paradigm proposed by Donabedian remains the one to use. Maxwell’s dimensions remain attractive to those who take the “public perspective” of quality as opposed to the “service” or “professional” perspective, to which Donabedian’s model is more suited. Many readers may be confused by the terminology of quality, audit, review, and evaluation Can evaluation be used to monitor, control, confirm, or refute effectiveness? It will require careful and concentrated thought to establish whether

evaluation of audit is the same as researching audit or even auditing audit. Confused? These two reports really can help.

The authors' analysis of the future direction of audit in the NHS may not be universally shared, although their list of

key issues is commonly accepted. That the authors have been able to draw together and usefully distil the evidence and methodologies used to evaluate audit bodes well for the next stages of their own evaluative study. Whatever your perspectives or involvement in audit, the

further reports promised should make not only interesting reading but will undoubtedly inform future policy and action.

BILL ENNIS
Medical Audit Facilitator

DIARY

11 April

London: Royal Society of Medicine Joint meeting with Forum on Quality in Health Care and the Section of Measurement in Medicine. League tables for health care? Further details from Mrs Nicole Taub, Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE (tel 071 290 2987; fax 071 355 3197).

17-22 April

London: Imperial College. World Congress of Occupational Therapists eleventh international congress. Developing opportunities. Session themes: children, community care, developing aspects of works in occupational therapy, education, elderly people, management, mental handicap/learning difficulties, physical disability, psychiatry/mental illness, and technology. (£390 approximately, excluding accommodation.) Contact Congress

Secretariat Conference Associates and Services Ltd, WFOT, 55 New Cavendish Street, London W1M 7RE (tel +44 71 486 0531; fax +44 71 935 7559).

20-24 June

Maastricht: University of Limburg, Summer University Health Sciences and Medicine. Quality assurance in health care. A working course focusing on quality management in health care institutions and on assessment of performance (either or both options may be taken). Contact Annie Simon, Summer University Health Sciences and Medicine (University of Limburg PO Box 616, 6200 MD Maastricht, The Netherlands (tel 31 43 881552; fax 31 43 881552).

22-24 June

London: First Euroquan conference on quality and nursing practice. Passport to quality. Contact Karen Waterman, Conference Manager, Passport to Quality, Viking House, 17-19 Peterborough Road, Harrow, Middlesex HA1 2AY (tel 081 423 1066).

NOTES

The Eli Lilly National Clinical Audit Centre was set up in May 1992 as a resource to medical audit advisory groups, health authorities, and others involved in audit. One of its current projects entails developing a package of audit protocols for primary health care teams, which can be used for standard setting and monitoring a practice patient's charter. Guidelines will be developed for standard setting in primary care, covering the main areas of access to health care (that is, waiting times); contacting the surgery (by telephone); and comments, suggestions, and complaints. The centre would be interested to hear from anyone who has completed an audit in any of these areas, particularly with regard to setting appropriate standards. Contact David French, Eli Lilly National Clinical Audit Centre, Department of General Practice, University of Leicester, Leicester General Hospital, Gwendolen Road, Leicester LE5 4PW (tel 0533 584873 fax 0533 584982).

QUALITY QUOTES

Perfection is attained by slow degrees; it requires the hand of time.

Loyal and efficient work is a great cause, even though it may not be immediately recognised, ultimately bears fruit – JAWAHARLAL NEHRU

It is reasonable to have perfection in our eye that we may always advance toward it, though we know it can never be reached – SAMUEL JOHNSON

The question "who ought to be the boss?" is like asking "who ought to be the tenor in the quartet?" Obviously, the man who can sing tenor – HENRY FORD

"If you could just fill out this 30 page questionnaire for us Mrs Green, we'll get round to seeing you shortly...."

Amusing or erudite items relating to quality – including examples of "quality speak", cartoons, etc – are welcomed for publication and should be addressed to the editor