Audit in general practice: where do we go from here?

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My local medical committee sent me here to say we want nothing to do with it. We’re quite happy the way we are. Our patients are satisfied, we are satisfied, and I don’t see any point in the whole business.1

These comments about audit, attributed to a conference delegate from Wigan, have a familiar and contemporary ring, although they were published over a decade ago. However, the same views expressed today would have more to do with a growing scepticism about what audit can achieve than with fear of the unknown, as was probably the case then. Although audit seems to be alive and well, with medical audit advisory groups (MAAGs) into their third year of activity; academics engaged in teaching and research related to audit;2 and a plethora of publications, conferences, and courses on the market, several problems loom on the horizon.

This paper briefly reviews the development of audit in general practice in the United Kingdom (UK) and considers three issues in detail – namely, the future role of MAAGs, how to involve consumers in quality, and how to incorporate audit into everyday practice.

State of the art

With MAAGs functioning in every family health service authority and health board district for over two years, the overall impression is that most practices have now formally participated in audit at some level. However, much of this activity has been piecemeal ("hit and run"), and a planned and systematic approach is established as yet in only a minority of practices. Furthermore, there has been little published work demonstrating sustained change, significant health gains, or improved outcomes as a result of audit.

Nevertheless MAAGs seem to have stimulated the release of much creative energy in their constituent practices, although the evidence is largely anecdotal. This they seem to have achieved partly by disregarding the Department of Health’s imperative to “direct, monitor and coordinate”4 in favour of a more facilitatory and enabling approach, and the range of methods used to involve practices have included visits, newsletters, multipractice projects, and educational events. MAAGs seem otherwise to have followed their brief in their involvement in audit at the primary/secondary care interface and multidisciplinary audit, and they are increasingly consulted about a wide range of service development issues. Nevertheless, individual MAAGs vary considerably in their approach, which is influenced by factors such as local medical politics and relationships with management. The roles and responsibilities of MAAG support staff have evolved rapidly, and these staff are increasingly recognised as having a key role in the development of audit.

NATIONAL AND EUROPEAN PERSPECTIVES

The Royal College of General Practitioners (RCGP) supports an extensive educational and training audit programme, and a national clinical audit centre has been established in Leicester. Doctors in training are now exposed to audit in undergraduate curricula2 and vocational training,3 and continuing education programmes increasingly include an audit component. In Europe, the UK and the Netherlands seem to be leading in many areas related to developing quality assurance and audit in general practice.5

Overall, the cautious welcome given by the profession to the introduction of medical audit in the NHS reforms6 has evolved into a grudging acceptance that audit serves some purpose, that it will prevail in some form, but that it is not a panacea and has important opportunity costs.

Audit in general practice

Published reviews of the development of audit in general practice3,7,8 show the picture as one of a steady trickle of work (starting in the early 1970s) mostly from enthusiastic individuals and academic departments. However the studies concentrated on describing practice, data collection and interpretation, and measuring performance rather than on demonstrating improvements in quality of care.

How much audit activity was going on at the same time in non-academic general practices can only be surmised. Nevertheless,

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... most of the developments in “ordinary” practices over the past two decades – care of patients with chronic diseases, the introduction of computers and practice management, and teamwork – and in education – vocational training, accreditation, and the work of young
principal groups – have had a quality dimension. A survey of activity in one district in 1990 concluded that many practitioners were already undertaking simple audit.10

LESSONS FROM THE LITERATURE
Although most of the theory and methodology of audit originated in North America, several significant contributions have been published in the UK, as follows. In a literature review Hughes and Humphrey identified a wide range of activities that seemed to help general practitioners in quality assessment, whether or not these activities were labelled “audit,” and these included practice visiting, peer review, and case analysis.8 Their work helped to widen the scope of audit and to set it in the broader context of quality assurance and service development. MAAGs and others involved in promoting audit were encouraged to adopt diverse approaches appropriate to local circumstances. In a second review Hughes and Humphrey used case studies to demonstrate ways in which audit had successfully contributed to both professional and service development, they noted some of the limitations of audit, and suggested ways of “making audit count.”9 The North of England study of standards and performance demonstrated how standards of care were set for common childhood conditions and the positive outcomes that accrued.11 It also contained important messages about the process of standard setting in groups. Another study, by Anderson et al, highlighted the problems of ownership and compliance with standards.12 Finally, Russell and Wilson13 argued the case for scientific rigour in audit while demonstrating that this does not necessarily imply complexity and in no way detracts from the “short and simple” approach to audit that has been widely promoted in general practice.

ROLE OF THE RCGP
The RCGP has long had a central role in promoting debate about quality issues, starting with the introduction of vocational training in the early 1970s. Its “quality initiative” in the mid-1980s had the aims that every general practitioner should be able, within ten years, to describe the content of their work and the services available to their patients and to incorporate standard setting and performance review into their everyday practice.14 The initiative stimulated enthusiastic activity in the faculties, and various methodologies, such as practice activity analysis15 and peer review by practice visits,16 were developed and tested.

However, these attempts at inspiring the profession were not widely successful. Many of the developments were ahead of their time and often required substantial effort for little apparent return. The results were usually described in publications unlikely to have a wide readership. Finally the initiatives provoked increased hostility among the profession owing to a perception that the college was colluding with the government in its reforms of the health service. Nevertheless, important lessons were learnt and the college helped to create a culture in which issues about audit and quality might be more readily aired, whether or not the aims of the quality initiative have been achieved.

LEGISLATION
The white paper made audit a contractual obligation for hospital consultants,7 but in primary care the government chose instead to establish an infrastructure for audit by creating MAAGs and thereafter left the profession (in collaboration with management) to organise audit voluntarily. Guidelines containing recommendations about membership, accountability, resources, and, perhaps most important of all, confidentiality, were given to family practitioner committees (of which the MAAGs are subcommittees) in a health circular. The groups were to be set up by April 1991, and all general practitioners were to be participating in audit by April 1992. The Department of Health allocated £1m annually to support MAAGs, as well as additional top sliced money to fund specific projects. This level of financial support for such a relatively loosely managed initiative may indicate the extent to which the Department of Health was committed to seeing audit develop at grass roots level under professional control, whatever the sceptics might have thought.17

Does audit work?
The answer to this question depends on our perception of the purpose of audit. For instance, the educational potential of audit has been widely recognised,18 notwithstanding problems that can arise in groups without appropriate facilitation skills.19 Whether audit is an effective method for promoting and sustaining change is uncertain. According to one commentator the money spent on audit has been “a wild gesture of optimism” because the appropriateness and effectiveness of audit have not been demonstrated.20 Nevertheless some benefits of audit have been shown, albeit in the short term.7 8 Reviews of strategies for implementing change in medical practice have emphasised the need for a flexible and creative approach21 – for example, Lomas has proposed the “coordinated implementation model,” in which audit and feedback have a fairly small role next to a range of other strategies, including the influence of opinion leaders and continuous quality improvement techniques.22 However, for most it remains an article of faith that audit has the potential . . . to facilitate change.

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What next?

The primary care service of the future will be more responsive to patients’ needs, with greater accountability for service quality. Substantial changes in general practice will be required, and are indeed taking place, including increased teamwork, expansion of the services provided, and greater involvement in purchasing care, all against a backdrop of a strategically managed health service. However, these changes will be achieved only if general practice comes to terms with the need to implement quality improvement strategies within the framework of modern practice management.24

In the continuing evolution of audit and quality assurance in primary care there are three important issues: the future role of MAAGs, how to involve the public in quality matters, and ways in which audit can be incorporated into everyday practice.

Change agents or double agents?

From the outset there was speculation about the challenges the new MAAGs might face – for example, questions about resources and how best to secure the involvement of all practitioners.25 26 More philosophically there was the need for MAAGs to embrace the principles of continuous quality improvement rather than concentrating on “bad apples.”27 One potential problem was a conflict between the MAAG’s responsibilities to management on the one hand and to its constituency of general practices on the other, particularly since the changes were being introduced at the time of the new general practitioner contract.28

Would MAAGs manage to command the confidence of the profession, thus enabling them to function as facilitators of change? In retrospect, they may have actually exceeded expectations. However, as the time for new guidance approaches it is worth considering what problems they now face and how these might be tackled.

VALUE FOR MONEY AND ACCOUNTABILITY

It is easy to see why some managers are beginning to question the return on their investment in audit since there is little hard evidence of the effectiveness of MAAGs. However, each MAAG has to provide its authority with regular reports; including a costed business plan for the forthcoming year with clear objectives (which many MAAGs do already) would seem to be one way of addressing accountability and insecurity about funding. The need for rigorous audit of MAAG activity is self-evident, and a range of indicators are emerging from evaluation studies which should prove useful (C Humphrey, personal communication).

MAAG PRIORITIES

Most MAAGs have promoted a “bottom up” approach to audit that is practice based and patient oriented.29 They are now under increasing pressure to direct some of their energies towards addressing management and service development issues (including quality aspects of purchasing) and at NHS priorities such as Health of the Nation.30 This will require something of a balancing act to avoid stifling local enthusiasm and “ownership” but could be negotiated locally as part of forward planning. More generally, workshops for clinicians and managers could also help to break down some of the barriers.31

To support developments necessary to maximise the impact of audit on quality of care, for example, encouraging multidisciplinary audit, MAAGs will need both to enlarge their remit and to alter their membership to reflect the whole constituency of interests in primary care.3 Many groups are already doing so, but such changes will result in them evolving into different organisations, possibly with a much reduced medical membership, and this will inevitably meet with some resistance from the profession.

Involving the public in quality

Described as one of the “real challenges in health care,”32 and emphasised by the patient’s charter,33 the public’s involvement in quality is yet to be properly addressed despite extensive coverage of methodology and much rhetoric. Donabedian eloquently described the role of “consumers” in quality assurance in health care – both as contributors to and targets of quality assurance and also as reformers – at several levels, starting in the consultation through to direct participation in the machinery of quality assurance itself.34 However, considerable advances are necessary for this to be realised in everyday practice in the UK. Even so, there is a long tradition of attempts at involving patients, ranging from postal questionnaire surveys35 to jars of beans in the surgery.36

SEEKING CONSUMERS’ VIEWS

Unfortunately, there are problems with all these approaches, for instance, whether lay members of patient groups are truly representative37 and the need to use properly validated instruments for measuring patient satisfaction.38 Donabedian recommends a range of strategies, from suggestion boxes to patients’ meetings, backed up by systematic canvassing of opinion. The value of cross sectional surveys has been questioned: satisfaction is a multidimensional phenomenon, heavily modified by patients’ individual experience of distress and other factors over which health professionals have little control.39

Whichever the approach adopted, it needs to be underpinned by a receptiveness by providers to suggestions for change and by the “absolute assurance that the respondent’s reports will be acted upon.”34 In this respect we do not yet have enough information about the methods most effective at producing change and the best ways of feeding back the information – again, more research is needed.

On a grander scale, Tudor Hart’s vision of a practice annual report being presented to an open meeting at which next year’s patient
committee is elected is a distant prospect for most practices, but the report does provide a possible mechanism for disseminating information to the public. A team manifesto also provides a framework for eliciting patients’ views as it contains explicit standards of care.

“DEMONSTRIC APPROACH” TO QUALITY
All these elements are brought together in the “democratic” approach to quality, proposed by Pfeffer and Coote. Combining responsiveness to individual needs with empowerment of individuals both as consumers of care and community members, the approach has several components: making relevant information accessible, allowing participation in decision making, increasing awareness of rights and choices, cultivating expectations, and relinquishing power and control. That is no mean feat.

MAAGs face an additional problem in lay representation, which many of them are moving towards. Community health councils have an obvious potential role here, although the problems that have beset patient participation groups may be re-enacted. Incorporating patients’ views into the processes of care and assessment of its quality, however, must start in the consulting room. Good communication is the basis of clinical problem solving and part of the therapeutic process, but it also provides an immediate and powerful quality feedback loop, and we should not underestimate its potential.

Making it all happen
Audit needs to be integrated into routine practice if it is to have a significant impact on quality of care. Unfortunately, from our knowledge of the way new ideas are adopted, audit has inherent disadvantages. Its “relative advantage” is difficult to demonstrate, and it does not fit easily into normal working practices. Audit often contributes more questions than answers, and it has major opportunity costs. Potential barriers to adopting audit are problems of perception, motivation, and implementation; thus those who are promoting audit will need to use a variety of strategies to help overcome them. The scale of the challenge should not be underestimated. However, successful models of change management have been developed in the general practice setting, and, again, an eclectic approach tailored to local need is likely to be the most successful option.

PRACTICAL BARRIERS
Lack of time for audit is a common complaint, and information handling is probably the most time consuming aspect of the whole process, although good quality information is crucial to effective audit.

The requirements for audit are relatively straightforward: a system that is clinically and administratively user friendly, data that are valid and reliable (implying the need for some standardisation and for clear thinking about their utility), and feedback that is timely and well presented. However, computers cannot help with the really difficult steps in audit, such as implementing change.

The practice annual report has great potential as a focus for audit, although the core data need to be standardised. The ideal would be a minimum data set that could support not only audit but other functions such as health needs assessment and purchasing.

However, even with efficient information systems, audit will still require dedicated time, a problem which delegation only partly solves.

STANDARD SETTING
Few would argue with the need to define and set standards of care, although standards in general practice present several problems. The science of standard setting is well developed, notably through work in the Netherlands, and benefits of standard setting have been demonstrated. But setting standards is time consuming, and clearly a trade off is needed between “ownership” and practicality. The advantages of a centralised approach include scientific validity and a broad legitimacy. The main disadvantage – namely, that such guidelines will be unacceptable – has not been the Dutch experience. We might consider establishing a central resource for guidelines similar to the UK clearing house for health outcomes. This would require the support of both the RCGP and the general medical services committee of the BMA, which has always adopted a cautious approach to audit and standards. Implementing guidelines is another problem. Not only are guidelines more likely to be adhered to if the user has participated in drawing them up but they also need to be clear and concise, ideally with patient specific prompts at the time of the clinical encounter; computers have great potential here.

CONTINUOUS QUALITY IMPROVEMENT: THE WAY FORWARD?
Continuous quality improvement is the most appealing approach, which despite its origins in industry has applications in health care. Its underlying principle – that most defects arise from problems in process rather than with individuals – requires effective team functioning, education and training, and good
quality information as prerequisites for its application. MAAGs have an important role here and may find their activities extending into areas such as team building. In trying to promote multidisciplinary audit taking the promotion of team function as the starting point may be more effective (North Tyneside MAAG, unpublished report). Whatever techniques are used, practice audit plans or manifestos provide useful frameworks for development on the ground.

Conclusions
The monograph containing the quote at the beginning of this paper asked three questions: Is effective medical audit possible in general practice? Does it produce any beneficial effects for the patient, the doctor, and the community? How can we ensure that the activity is practised by all doctors and not just a keen band of innovators? Ten years later we have a clearer idea of where audit fits into the broader context of quality assurance and service development. We know that audit on a limited scale is possible in general practice and can bring about beneficial change, at least in the short term. Certain developments, notably the establishment of MAAGs, have helped to create a climate in which critical review of practice is more likely, and the extent to which this has happened at a time of imposed change and flagging professional morale is remarkable. However, systematic audit is not yet part of routine practice, and the link between audit and service development remains weak.

Audit in general practice is still voluntary, although the new requirements for reporting about chronic disease management require simple audit. It is unlikely to become a contractual obligation as it would prove almost impossible to monitor and would have a negative impact on enthusiasm and activity; in any case there is still commitment from the centre to a professionally led quality process. MAAGs are now part of the culture of primary care and have a key role in future developments, notably by promoting the principles of continuous quality improvement, but they will need to undergo change themselves to respond to the challenges facing the health service.

Many questions are still unanswered, and more research and evaluation of methodology are clearly required. The audit and quality movement has a momentum which is unlikely to diminish, but quality has a price funding agencies please note.

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References
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