Dr Frank Sullivan and Professor John Bain, respectively senior lecturer in and professor of general practice, describe general practice audit in Scotland from the viewpoint of “the audit activists.” General practice audit in Scotland has been moving ahead without the benefit of the medical audit advisory group (MAAG) structure found in England and Wales.1 Instead, the Clinical Resource Allocation Group (CRAG);2 the Scottish Office’s department responsible for health boards a great deal of local autonomy.3 As a result progress has occurred at different rates and by various different paths. In an attempt to obtain evidence about how medical audit in general practice in Scotland is progressing, fifty six “audit activists” (facilitators, advisers, lecturers) were visited during 1991-2 by JB, who used a semistructured interview to obtain their views.

Getting started
In some cases audit topics selected themselves with existing high quality work continuing – for example, that of Maitland et al in Grampian who have shown how audit increased recording and improved the management of cardiovascular risk factors.4 In other instances the audit sub-committees took the initiative – for example, in Lothian where a menu of 15 audit projects was offered to all five hundred and twenty eight general practitioners (GPs). Three hundred and ten GPs have become involved in seven projects. This approach has been followed in Lanarkshire, where five of the eight projects offered were derived from the Lothian list.

Other health boards, such as Glasgow and Argyll and Clyde, divided their health boards geographically to support local audit activities, with a GP facilitator to provide advice and practical help through practice visits and by telephone contact. The locally based approach in each area has encouraged ownership of the topics selected for audit projects. There has also been a slowly increasing trickle of requests from individual practices for support to conduct particular audit projects. Often these requests are in the areas of practice management such as appointment systems and patient satisfaction with specific services.

The least success in getting started occurred where sub-committees struggled with their formation and responsibilities, often owing to local medico-political considerations. Other problems arose when projects were started without wide enough consultation. In these circumstances the projects did not gain much support.

Getting going
As the “1990 contract” showed, fixed targets are achievable by most practices. Whether this is preferable to more locally owned standards is, however, debatable. Setting standards is often the most difficult part of the audit process for GPs, who are accustomed to a high degree of clinical autonomy. 5,6 It is crucial, however, because it is against locally “owned” standards that the success of audit will be measured.7 The Lothian and Lanarkshire area wide projects have allowed locally agreed standards to be developed because local peer group comparisons are available anonymously. GPs usually prefer Berwick’s concept of “continuous improvement”8 to comparison with stated numerical levels of performance which may be construed as implying a pass/fail judgement on their clinical skills. For example, most seem to prefer to say, “We are aiming to perform two yearly urine analysis on more of our hypertensive patients than we used to” rather than, “80% of hypertensive patients must have urine analysis performed every two years.”

One of the reasons for this is that the concept of standard setting is seen by GPs as an undesirable shift in emphasis from “personal care” to “population care.” However, other GPs involved in audit see the dichotomy as more apparent than real believing that raising standards for groups of patients will usually raise standards for those individuals currently receiving the lowest standards of care. Nevertheless, the process of making the standards of care to be expected by patients and delivered by GPs explicit remains very threatening to many doctors. This is particularly true when audit of “outcome measures” is attempted in a climate of lack of agreement on what is acceptable as an outcome measure for many clinical situations, let alone what is the acceptable standard.

The data you have are never the data you need...
GPs’ records are not designed with audit in mind. They represent a contemporaneous aide-memoire of each consultation, which has been likened to a “single frame in a long running cine film.”9 Hospital letters and laboratory reports in the GP notes supplement this function, but extracting information is often time consuming. When specific questions were asked prospectively the effort of data collection became even more onerous. Solutions pursued have included the use of trained audit facilitators visiting practices to enter data directly onto a laptop computer. Currently, 77% of Scottish practices use GPASS (General Practice Administration System, Scotland) which may be interrogated using the ANALYSE program and electronic questionnaire developed in Aberdeen.10 Comparisons of diagnostic and therapeutic data are then available on a national basis for topics which are suited to this approach.

Comparisons may not be possible between measurements such as episode rates if precision about the denominator and sampling is not fully understood.10 11 One example which caused concern was the experience of being shown details of a group of patients for which no denominator was available for the population from which it had been selected. Some areas have tried to establish advice and administrative resources to guide and support practices through some of these difficulties and pitfalls. Several “GP audit offices” with secretarial facilitation and non-medical audit assistants perform this function now.

Making improvements
Audit is a key which unlocks many of the darkest secrets in a practice; if these are successfully confronted then the practice may grow from strength to strength. However, the sensitive issue of partnership agreements/relati-
ships has often been the stumbling block to practice based audit. Another problem was that when the benefits to be expected were not defined at the outset of a project it was often difficult to assess the importance of any observed change. Sometimes the initial enthusiasm for producing benefits was forgotten as the scale of the problems was realised. Successful audit activities predicted the likely problems to be faced and considered how improvements were to be achieved at the design stage.

Involving others

The importance of all practice team members and their inter-relationships and interactions with other agencies are crucial to making improvements. Spiegel et al have recently reviewed how helpful and hindering forces operate at a practice level. Their model identifies all “stakeholders” involved in a proposed change and considers the costs and benefits to each practice member of complying with or wrecking the plan. Similar forces have been observed at a health board level when the appropriate managers have not been involved.

The hindering forces are often then characterised by doctors as the clash between “clinical” and “managerial audit.” For example, it took a considerable time for several of the health boards even to establish GP audit sub-committees. Once in existence, the committees then struggled to obtain clear guidelines on the requirements. Often, leading to a great deal of frustration in the early stages of the process. Staff employed to work on GP audit became health board employees but under the direction of self employed, independent GPs. Health boards were reluctant to reimburse GPs involved in audit further so that, much audit work was performed in the doctors’ (and their families’) time without recompense.

Of course not every audit project requires funding from outside the practice, but for those that do, clear application forms and processes are appreciated.

Next steps

A stage has been reached in Scotland when the ways and means of bringing about change through audit need to be thought through more carefully. The support systems to ensure that this will occur vary greatly from area to area, and to avoid isolation a network of support is needed for GP audit facilitators and coordinators. Health service research networks, which exist throughout Scotland, are one source of support, with access to expertise in statistics, health economics, sociology, etc. Other important links are with the regional adviser network and the faculties of the Royal College of General Practitioners to ensure that proposed and completed studies may be subject to peer review.

The skills needed by those in leadership positions in general practice audit have been described earlier, as follows:
- identifying questions that are both relevant and important
- group leadership
- data handling
- intervention strategies.

Postgraduate courses and publications cover many of these items but are aimed primarily at doctors. Many of those involved in audit are not medically qualified — for example, audit assistants, practice managers, and health board administrative staff. If audit in primary care is to move forward in a manner which not only involves the providers of care but also relates to the needs of patients then a multidisciplinary approach requires serious consideration. To take one practical example: if groups of GPs are involved in reviewing the care of diseases in a range of practices but the practice managers and audit assistants are not involved in the planning and development of the project and are excluded from the results of feedback, then their commitment may be less optimum and the information less rigorously collected.

If health boards are to maintain a commitment to audit then continuing education of those responsible for making it happen will have to ensure that resources for developing the required skills match the expanding information technology. Audit facilitators should be valued, nurtured, and encouraged. Otherwise there is a danger of systems and structures taking over when the true spirit of audit has to remain that of seeking good questions about how to improve patient care. Given the demonstrated commitment to audit in Scotland such a scenario seems unduly pessimistic. Indeed, if these early reports of progress up the audit spiral are confirmed then those GPs who have declared their resistance to audit may yet be persuaded that it is a valuable exercise.