08901

# PROMOTING MEDICAL AUDIT IN PRIMARY CARE:

# A QUALITATIVE EVALUATION OF MEDICAL AUDIT ADVISORY GROUPS

THESIS

presented for the

DEGREE

of

DOCTOR OF PHILOSOPHY

in the Faculty of Medicine

Field of Study

Health Policy

by

CHARLOTTE MIRANDA HUMPHREY

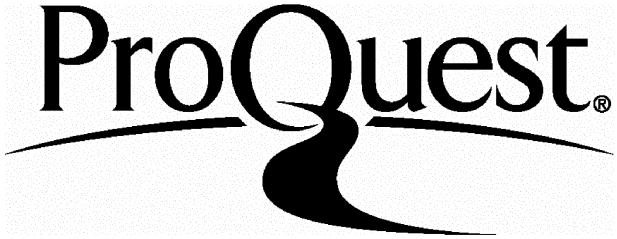


Department of Primary Care and Population Sciences

Royal Free Hospital School of Medicine

University of London

May 1996



08901

## ABSTRACT

The 1989 policy on medical audit in primary care required each family health services authority (FHSA) to establish a medical audit advisory group (MAAG) to direct, coordinate and monitor medical audit activities among all general practices in its district. The aim of the thesis is to assess the capacity of the MAAG structure to fill this role effectively.

The thesis includes analysis of the historical and political circumstances surrounding the introduction of the policy on medical audit, discussion of the principles and practice of audit in general practice and a brief review of what is known about the effectiveness of audit in bringing about improvements in patient care.

The empirical core of the thesis is a qualitative study of the activities and progress of 15 MAAGs in two English health regions undertaken in 1992. The purpose of the study was to inform future development of policy and practice in relation to MAAGs at both national and local levels by a) "mapping" the implementation of the MAAG programme in order to develop knowledge and understanding of how different MAAGs had evolved, what they were doing and why they were working in particular ways; and b) using the knowledge and insights gained from this exercise to assess and explain progress (or lack of it) towards achieving the objectives of the audit programme. The methodology of the study involved semi-structured interviews with MAAG chairs and support staff and FHSA managers and independent medical advisers in each of the 15 study districts and analysis of relevant documentary material.

The findings of the study show that the study MAAGs were broadly working in accordance with their brief. They were also playing a valuable role in supporting primary care development. Nevertheless, in most respects the detailed expectations of the audit programme were not being met, nor were the anticipated benefits apparently being achieved. The study findings provide the basis for a discussion of the viability and appropriateness of the MAAG structure as a means of promoting audit in primary care which also takes account of the developments that have taken place in relation to MAAGs in the three years since the data were collected.

For Piero and Oskar

## ACKNOWLEDGEMENTS

I am grateful to Dan Altmann and Gerry Shaper for encouraging me to begin and to Jane Hughes for helping me to find the subject. It was through our collaborative work for the King's Fund that I developed my initial knowledge of audit in general practice and the enthusiasm for further study in this area.

I am greatly indebted to Diane Berrow and Elaine Harris who worked with me on the evaluation for the strength of their commitment to the study and their continuing support and encouragement since it was completed. I would also like to thank Rosemary Field for her consistent support of this work and for making my involvement with the NHS Executive so enjoyable and productive.

While writing this thesis I have received much encouragement from my friends and colleagues. I would particularly like to thank Mark McCarthy, David St George, Peter Whincup, Jonathan Elford, Pandora Pound, Richard Morris, Sheila Hillier and my supervisor Shah Ebrahim for all their advice and support.

## TABLE OF CONTENTS

## TABLES AND FIGURES

## LIST OF APPENDICES

# INTRODUCTION

Medical audit was introduced in the 1989 white paper *Working for Patients* as a "fundamental principle" of the National Health Service (NHS) reforms (Secretaries of State 1989a). Before that time, doctors in a number of different specialties had participated in audit, but this involvement was a matter of personal or professional choice. Maintenance of clinical quality had always been regarded in Britain as an internal matter for the medical profession. As such it was an area in which, until 1989, no government saw fit to intervene. However, included among the objectives of the 1989 white paper was the explicit requirement that "every doctor" should participate in "regular, systematic medical audit". In support of this objective two new types of local support structure were to be created and resourced. The new organisations for supporting audit in hospital and community health services were called medical audit committees. Those whose job was to promote audit in primary care would be known as medical audit advisory groups (MAAGs). These audit groups were to be led by clinicians, but would be funded through and accountable to their local health authorities. Thus, for the first time, the promotion of activity to improve the quality of doctors' clinical care became a matter of government policy and local NHS management.

The policy on medical audit was presented as one of the key components of the reforms and much was expected from it. The anticipated benefits of audit, as described for example in an internal Department of Health discussion paper (NHSME 1991 p.3), were both profound and wide ranging:

> *"Medical audit should trigger changes in practice within specialties, across specialties, across provider units and across boundaries including those between primary, secondary and tertiary care. The findings of medical audit should encourage comparison and challenge working practices throughout the NHS...This should result in optimal delivery of effective and appropriate care by the right professionals, in the right combination, in the right setting and at the right time."*

Besides these direct benefits for patients, it was thought that the existence of an effective programme of medical audit would help reassure doctors, patients and managers that attention was being paid to maintaining a high quality service. The arrangements introduced to get audit established involved a large number of people and a substantial investment of money. In addition, although no funds were allocated to pay individual doctors to do audit, as participation in audit increased there would be growing indirect

costs in terms of clinicians' time. But the ambitions for medical audit - if they could be realised - were expected to more than justify the resources invested.

In practice, there were many reasons for uncertainty as to how the policy on audit would actually turn out. As will be discussed later, the concept of audit was fraught with difficulties, there was disagreement about its purpose and limited experience of its methods, the process and dynamics of doing audit were known to be complicated and there were doubts about its effectiveness in day to day use. Moreover, the organisational structures being set up to support the policy on medical audit were entirely new and the anticipated relationship between profession and management was controversial.

In primary care, the unpredictability was further compounded by the turbulent state of general practice and the fast evolving organisational environment into which the new audit groups were introduced. When MAAGs began work in April 1991, GPs were one year into dealing with a new and controversial contract which many of them were very unhappy about (Secretaries of State 1989b), the first wave of fundholders were just getting off the ground in accordance with the new arrangements introduced in *Working for Patients* for GP budget holding and many practices were also in the middle of computerisation. At the same time, those responsible for the administration of primary care services were grappling with a new management structure and extended responsibilities for overseeing the implementation of national policies and the local development of primary care following the transformation of family practitioner committees into family health services authorities (FHSAs) in the previous year. Thus both the sponsors of the MAAGs and the practices whose audit activities they were supposed to be supporting were facing a range of new challenges quite apart from those concerned with establishing audit.

As with most other components of the 1989 reforms, there were no built in arrangements for evaluating the MAAG initiative and no formal arrangements for monitoring its progress. Consequently, especially in the early days of implementation, there was little systematic information available about what the MAAG programme was producing on the ground. For those in the Department of Health who were responsible for the policy, as for people who were involved with MAAGs at local level, knowledge about what was happening around the country was based on informal contacts and experiences exchanged

at locally organised meetings. The one feature of MAAGs that was evident to everyone was the considerable variation in the approaches they were taking, but little was known in detail about the nature of, or reasons for, these differences.

Subsequently several national surveys of different aspects of the MAAG initiative were undertaken. The focus and findings of the various studies are discussed in detail in Chapter Four. They generated mostly quantitative data about various aspects of MAAG structure and activities which were specified in the original instructions given to MAAGs (Department of Health 1990b). What these studies did not provide, however, was any information or explanation as to how far MAAGs were adhering to their intended agenda or where and why they might be departing from it. Nor did they enable any assessment of the quality of the work MAAGs were doing. From discussions held by the author in the early 1990s with a range of primary care practitioners and managers attending workshops and courses on primary care audit it became clear that a study which provided some systematic answers to such questions would be welcomed by everyone involved at a local level so that useful experience might be shared. Those responsible for primary care audit in the NHS Management Executive were also interested in obtaining information of this kind to inform the further development of audit policy and to assist the Department of Health to account to the Treasury for monies spent in this area.

In the spring of 1992, MAAGs had been in existence for just over a year and should, in theory, have produced their first annual reports. Having started from nowhere, their functions, activities and relationships were still evolving and would almost certainly be subject to further change. But, to the extent that they had established their membership and embarked on a progamme of work, they could be assumed by then to have developed at least an initial identity. Given that no formal evaluation had been built in from the start, this was arguably the earliest point at which a systematic investigation of what the MAAG policy had produced could reasonably be attempted. While any conclusions would inevitably be provisional and might well become outdated as the MAAGs matured, the doubts described above about the policy's viability, the shortage of information and the widespread interest in knowing more appeared to provide adequate justification for an early exploratory study.

The purpose of such a study would not be to judge the MAAGs' success in achieving

their given objectives, since it was still too soon for a summative assessment of that kind. Rather, the aim would be to ascertain whether and how effectively they were actually working towards those goals and what else they might be doing. Following discussions between the author and the NHS Management Executive, a proposal was developed and funding agreed for the qualitative evaluation of MAAGs which is the subject of this thesis.

The objectives of the study were: First, to "map" the implementation of the MAAG programme as comprehensively as possible, taking account of the influence of the wider policy context as well as local demographic and organisational factors, in order to develop both knowledge and understanding of how different MAAGs had evolved, what they were doing and why they were working in particular ways. Second, to use the knowledge and insights gained from this exercise to assess and explain the progress (or lack of it) towards achieving the objectives of the audit programme.

### *Structure of the thesis*

*Background*

In order to understand the problems and opportunities facing MAAGs and their responses to these, it is necessary to know something of the historical and political circumstances surrounding the introduction of the policy on medical audit and about audit itself. The first three chapters supply this background. CHAPTER ONE describes the wider concern with quality assurance in the NHS. It shows how issues of clinical quality were initially excluded from NHS policy and then discusses the factors that eventually led to the introduction of a programme of quality assurance for doctors in the form of medical audit in the 1989 white paper *Working for Patients*. CHAPTER TWO begins by describing what medical audit is and the principles and assumptions that underly it and goes on to discuss the place of audit in the range of professional and managerial activities concerned with assuring the quality of general practice. The chapter concludes with a brief review of what is known about the effectiveness of audit in bringing about improvements in patient care. CHAPTER THREE outlines the objectives of the 1989 policy on medical audit and describes and compares the proposals for supporting the development of audit in hospital and community health services and in primary care. Reactions to the proposals

from the medical profession and others are then described.

*The study*

The next two chapters set the research context for the qualitative evaluation of MAAGs and describe the study. CHAPTER FOUR reviews the scope and findings of studies undertaken to monitor and evaluate the audit programme in primary care and defines the purpose and nature of the qualitative evaluation of medical audit advisory groups which forms the empirical core of this thesis. CHAPTER FIVE describes the methods adopted for the evaluation, discusses some practical aspects of the conduct of the research and considers measures taken to address the issues of reliability, validity and generalisability. Characteristics of the respondents are also outlined.

*Study findings*

The next four chapters present the study findings. CHAPTER SIX begins with a brief description of the study districts. It goes on to look at how the study MAAGs were set up, the nature of their membership and staff and the resources available to them in terms of funding and other facilities. A number of differences are identified between the initial make-up and circumstances of the various MAAGs which help explain the contrasting perspectives and strategies they subsequently adopted. CHAPTER SEVEN outlines the purpose and function of the MAAG as defined in the MAAG circular (Department of Health 1990b) and considers how these definitions compare with the views of audit and the MAAG held by respondents in the study districts. The distribution of views between different groups of respondents and the role of each group in determining MAAG policy and practice is then discussed in order to ascertain how the outlook and strategies of the study MAAGs themselves were informed by the various views identified. CHAPTER EIGHT describes how the study MAAGs actually went about their task of directing, co-ordinating and monitoring medical audit activities within the practices in their districts. The chapter focuses on three key aspects of the MAAGs' work - their contact with practices, the approach taken to audit and their activities with regard to monitoring and accountability. CHAPTER NINE discusses respondents' views of their own MAAGs and their perceptions of the strengths and weaknesses of the policy on medical audit and the provisions contained within the circular which created the MAAGs.

*Assessment*

CHAPTER TEN begins by reflecting on the progress made by the study MAAGs. An assessment is made of how far the MAAGs were working in accordance with the government's expectations and how far the anticipated benefits of the audit programme were already being realised or seemed likely to be realised in the future. Information from a variety of other sources is then used to consider how MAAGs developed after 1992/93 when the data for the present study were collected. The chapter ends with a discussion of the strengths and weaknesses of the MAAG programme over the whole five-year period during which MAAGs existed in their original form. CHAPTER ELEVEN concludes the thesis by returning to the aims and purposes of the evaluation, assessing the extent to which they were fulfilled by the study and reflecting on the use made of the findings in the three years since the data were collected.

## Chapter One

# QUALITY ASSURANCE IN THE NATIONAL HEALTH SERVICE

This chapter traces the emergence and nature of the concern with quality in the National Health Service and shows how the clinical activities of the medical profession were initially excluded from NHS quality assurance policy. This exclusion is seen to derive from the traditional autonomy of the medical profession. Changing attitudes to medical autonomy since the start of the NHS and governments' attempts to increase the accountability of the profession are then described. The chapter concludes with a discussion of the factors that eventually led to the introduction of a programme of quality assurance for doctors in the form of medical audit in the 1989 white paper *Working for Patients*.

### *Approaches to quality assurance*

The "quality" of a service has been defined as the totality of features and characteristics of the service that bear on its ability to satisfy the stated or implied needs of the users of that service (Pollitt 1990). More specifically with regard to health care, the World Health Organisation's working group on quality assurance (WHO 1985 p.5) suggests that a quality service is one in which:

> *"Each patient receives such a mix of diagnostic and therapeutic services as is most likely to produce the optimal achievable health care outcome for that patient, consistent with the state of the art of medical science, and with biological factors such as the patient's age, illness, concomitant secondary diagnoses, compliance with the treatment regimen, and other related factors; with the minimal expenditure of resources necessary to accomplish this result; at the lowest level of risk of additional injury or disability as a consequence of treatment; and with maximal patient satisfaction with the process of care, his/her interaction with the health care system, and the results obtained."*

A wide range of different activities contribute to ensuring and enhancing service quality. These include:

* *needs assessment* - finding out what users' needs are;
* *research* - finding out how those needs may be met effectively;
* *dissemination and guidelines* - making research findings available in an appropriate and accessible form;

* *education* - making sure that service providers have the skills, knowledge and commitment to enable them to meet users' needs; and
* *service planning* - ensuring that structures/systems are appropriate and adequately resourced.

In addition to these there is the activity of "quality assurance". The term "quality assurance" is usually used to refer specifically to methods of maintaining or enhancing service quality which use systematic assessment of performance against predetermined standards as a means of identifying problems in the service and of introducing and monitoring improvements. Quality assurance is a separate activity in its own right but it is also intimately linked with all the other activities listed above. For example, knowledge gained from needs assessment may be used to define the aspects of the service to be subject to the process of quality assurance and research findings provide the standards against which the service is assessed. In turn, quality assurance may show up problems in relation to service organisation, resource provision or education or identify the need for improved guidelines or further questions for research.

The objectives and practice of quality assurance programmes vary depending on how quality is thought about and this is an area where attitudes and assumptions have changed considerably in the past few decades. Until relatively recently, quality assurance programmes both in industry and public services were based on principles of "scientific" management developed in the era of mass production and assembly-line working methods and predicated on the preeminence of "expert" knowledge (Pfeffer and Coote 1991). In this approach, all aspects of quality assurance are controlled by experts, including the specification of which components of the service or product are important, the setting of standards and the monitoring of conformance to those standards. Quality control in these circumstances typically involves external scrutiny of products or activities by people with specific responsibility for identifying faults and rooting out substandard work. The emphasis is on dealing with transgression of standards rather than enhancement of quality and the focus tends to be on looking for problems in the individual elements - looking for the "bad apple" in the barrel - rather than in the process as a whole. When a fault is found it is dealt with by removal or exclusion.

In the 1950s, a new management philosophy which subsequently became known as "total

quality management" (TQM) was developed in the United States. This differs in several important ways from the more traditional approach described above. First, on the principle that customer satisfaction is the key to organisational success and that satisfaction will be maximised by giving the customers what they want, the TQM approach eschews expert criteria for quality in favour of customers' definitions of their own needs. Second, quality assurance is regarded not simply as a way of maintaining standards, but rather as a means of raising those standards and thereby increasing organisational success. The aim of TQM is to achieve continuous improvement in quality by constantly seeking out and acting upon opportunities to do things better. The identification of a fault is therefore seen as a positive event rather than an occasion to attribute blame. Problems of quality are assumed to derive from weaknesses in the system rather than individual failings and are dealt with by looking again at the system rather than punishing or removing the offender. It is taken for granted that everyone does their best. Finally, TQM encourages all participants in an organisation to take responsibility for the pursuit of quality in their own area of work, so quality assurance becomes a generic internal activity rather than a matter of external monitoring of one part by another (Berwick 1989).

The TQM approach was initially adopted by major Japanese manufacturers. Subsequently, American and European firms increasingly followed their lead, but in Britain the approach remained confined to isolated pockets of manufacturing and retailing industry until the 1980s. Pfeffer and Coote (1991) identify the 1982 publication of the best-selling book *In Search of Excellence: Lessons from America's Best-Run Companies* (Peters and Waterman 1982) as the catalyst which turned the pursuit of quality into a mangerial "holy grail" in Britain also.

### *Quality assurance in the NHS*

When the NHS was established it was assumed that expenditure on health services would decline once the backlog of ill health thought to exist in the community had been eradicated. It was subsequently recognised that this assumption was false. Far from declining, the demand for health care is potentially limitless as expectations rise and the development of new techniques opens up new opportunities for treatment. Between 1949 and 1984 the real cost of the NHS increased threefold and the proportion of the gross

national product spent on it increased from 3.9% to 6.2%.

In the early 1980s it was estimated that an increase in funding of 1.2% per annum was needed to meet the costs of care for an ageing population and to fund advances in medical technology (Ham 1985). The government of the time, however, was strongly committed to restraining public expenditure and loath to provide more money for the NHS. Instead, attention was increasingly focussed on reducing inefficiency as a means of improving and extending services without increased costs. A series of initiatives were introduced by the Department of Health between 1981 and 1983 with this aim in view. These included requiring health authorities to make annual efficiency savings of between 0.2 and 0.5%; initiating "Rayner scrutinies" i.e. short intensive studies of areas affecting the efficiency of the NHS such as transport services and recruitment advertising; publishing performance indicators relating to clinical services, finance, manpower and estate management to enable health authorities to compare their performance with what was being achieved elsewhere; and introducing the principle of competitive tendering to test the cost-effectiveness of health authorities' own catering, domestic and laundry services. In 1982 a team led by Roy Griffiths, the Deputy Chairman and Managing Director of Sainsbury's was appointed to give advice on the effective use of management and manpower and related resources in the NHS. The main thrust of the critique offered in the resulting *Griffiths Report* (1983) was that the NHS lacked a clearly defined general management function. Accordingly, it was recommended that general managers should be appointed at all levels in the NHS to provide leadership, introduce a continual search for change and cost improvement, motivate staff and develop a more dynamic management approach.

Up to this point, concerns about "quality" per se appear to have been absent from NHS thinking and policy documents. In the second half of the 1980s however, with the new influx of managerial ideas from areas of industry where the TQM approach had already been adopted, the pursuit of quality became an increasing managerial preoccupation. Insofar as the absence of quality in processes of work had been repeatedly identified as a major cause of high costs (Berwick et al 1992) and attention to quality was perceived as a way to improve services without increasing costs, TQM was seen as a powerful way of addressing continuing concerns about value for money. In addition, the term "quality" itself had inherently positive connotations which made it a valuable new focus in an

environment where the pursuit of "efficiency" had become widely regarded as a euphemism for making expenditure cuts. Belief in the TQM approach to quality with its focus on customer satisfaction was also reinforced by its perceived compatability with the growing consumerist ethos among the general public and by government emphasis on increasing patient choice.

Not everyone was persuaded of the appropriateness of applying an approach to quality originating in the manufacturing industry to a complex non-commercial service sector such as the NHS. For example, the Audit Commission observed in a consultation document on its own role in health service quality assurance (1992 p.7), that the TQM approach was designed:

> *"To assure quality where there are clearly defined repetitive processes, where desirable end products are recognisable and result in an understood way from the process, and where the inputs are very similar. All of this is very different from health care, where the process is often customised, the desired outcome difficult to define, the link between them seldom well understood, and the concerned "inputs" i.e. patients, are very different from one another."*

But the Department of Health was forthright in its advocacy. In a guide to TQM in the NHS (NHSME 1993a p.3) the Management Executive prefaced its report with an explicit commendation of the Ford company's adage "everything we do is driven by you" and set about tackling potential criticism head on:

> *"What sense can it make to translate the experience of Japanese economics to the health service? What do Japanese hi-fi or robotics have to do with better care for patients? After all, the delivery of health care is infinitely more complex than manufacturing video recorders...The answer lies in looking behind the scenes to see what is really needed to produce quality goods or services. To meet customer requirements the organisation, whether a factory or hospital, needs to work well. If there are hitches and delays in the workings of a hospital, just as in the manufacturing process, resources are wasted. If there are defects in the work X-ray passes on to the physiotherapist, just as in the production line, ultimately the customer suffers. In a total quality organisation, resources are better managed, people co-operate and the organisation is more flexible and responsive to its customers. This can work for the NHS, as it worked for Japanese business."*

The adoption of the new approach to quality in the NHS was reflected in a burgeoning of total quality management schemes, quality circles, quality standards and quality charters. These involved an enormous range of diverse activities from training in "customer awareness" for all staff to improving the physical environment by planting spring bulbs; from a scheme to empower elderly patients by involving them in recording

their experiences of health care as they journeyed through the different services to the introduction, on the initiative of a hospital portering department, of low-profile mortuary trolleys. The common feature of all such schemes was an emphasis on listening to patients and acting on their requirements and on involving staff at all levels in identifying problems and developing solutions. In 1989 a survey of quality assurance initiatives in the NHS produced details of 1,478 specific initiatives in 116 districts and the growth of such initiatives could be said to have reached "epidemic" proportions (Carr-Hill and Dalley 1992).

In one very important respect, however, the developing managerial focus on quality in the NHS differed from the industrial models on which it was based. Far from involving all parts of the organisation, quality as an issue in the NHS was quickly divided along "tribal" lines. Pollitt (1993a) distinguishes between *medical quality*, the definition of which remains a professional exercise conducted exclusively by doctors, *service quality*, which comprises the many aspects of providing health care services which remain once "doctors' business" has been artificially extracted and which is seen largely as the province of nurses and managers, and the user's *experienced quality*, about which currently least is known. Notably, concern with the quality of medical work was consistently excluded from health authority remits for quality management. Pollitt comments on the "hollow-centered totality" of the 23 pilot TQM schemes funded by the government in 1989, whose concerns were actually total quality *minus* medical quality. This does not mean that doctors were excluded from participation. On the contrary, their involvement was seen as vital because of their increasing involvement in the management of service delivery and their leadership role. But the NHS Management Executive's *The Quality Journey* (1993a) which reported on progress in these demonstration sites made it quite clear that the TQM projects were not intended to address quality within professional boundaries nor to impinge on the exercise of clinical judgement.

Writing about this situation in 1989, Moores (1989 p.325) commented that:

> *"To exclude the primary activity of the business deliberately from any quality management programme would be considered unusual, if not downright silly, in virtually any other industry. But we are dealing with an atypical industry, and the unique position of the clinicians in the NHS has enabled them to remain outside any real performance appraisal system since the inception of the NHS."*

The origins of this "unique position" may be traced back to the 1858 Medical Act which,

in establishing the General Medical Council to regulate the medical profession on behalf of the state, legitimated the profession's claims to autonomy and its right to self regulation.

*Medical autonomy and professional accountability*

When the National Health Service was created in the 1940s, doctors, alone among health care providers, were given a key role in the planning and running of the new service by their presence on Regional Boards and Hospital Management Committees. In addition, the rights of the medical profession to collective autonomy and individual clinical freedom were both taken for granted and explicitly acknowledged in the 1944 white paper *A National Health Service* (Ministry of Health 1944). Klein (1983) argues that the special role and concessions accorded to the medical profession reflected three key beliefs prevalent at the time: that medical science had not only triumphed over disease and illness in the past but would continue to be the key to doing so in the future; that medical support and co-operation was crucial to the success of the proposed health service; and that professional autonomy was both a necessary and appropriate form of management for those essential, and essentially benevolent, occupational groups such as medicine whose esoteric knowledge bases required them to be self-governing and independent from interference by the state.

Since that time, both the necessity of medical autonomy and its advantages for the general population have been called into question. The first major theoretical challenge to the medical profession's claims to special status came in 1970 from the American sociologist, Eliot Freidson, who argued that the emphasis on professional autonomy had more to do with the major advantages it offered to the profession's own members than any natural or inevitable need on the part of the public (Freidson 1970). At the same time, concern was beginning to be expressed from a wide variety of sources including patients and consumer groups, paramedical professions and governments about the detrimental consequences of medical dominance and lack of accountability both at the level of individual patient care and for the health service as a whole. Criticism focussed on diverse aspects of medical practice including the tendency for care to reflect professional priorities and boundaries rather than patient needs, resulting in comparative neglect of "Cinderella" services such as those for older people and mental illness that are associated with low status in the professional hierarchy (DHSS 1976); the narrow focus on

identifying specific causes of disease in individuals and the concomitant neglect of social and environmental causes of ill health (Doyal and Pennell 1979); the damage to patient autonomy caused by excessive paternalism (Cox and Mead 1975); and the wider dangers of dependency associated with the medicalisation of social problems (Illich 1977).

This disquiet was reinforced by growing doubts about the validity of the claims used to justify the special position of the medical profession i.e. the key role of doctors in the maintenance and restoration of health and the ethical commitment of the profession to putting patients' interests first. Among the events which fuelled this reassessment were the publication of studies of the role of the medical profession in the decline of mortality from infectious diseases which argued that doctors had overestimated the results of their own interventions (McKeown 1979; Powles 1973) and the findings and recommendations of the working group appointed in 1977 to assemble the evidence about inequalities in health which were published in the 1980 *Black Report* (Townsend and Davidson 1982). The report documented the existence of a marked class gradient in standards of health which had, if anything, become steeper since 1948. It argued that much of the problem lay outside the scope of the NHS and called for a radical overhaul of the service-dominated approach to the problems of health. In addition, concern about medical responsibility was raised by the findings of investigations into the running of long-stay institutions for mental illness such as the Ely Hospital enquiry (HMSO 1969) which blamed the doctors in charge for the inadequate care revealed. Finally, belief in the service ethic of the profession was undermined by events in the mid 1970s such as the industrial action taken by hospital doctors in pursuit of more money and the decision by senior medical staff to treat only emergency cases as a protest against the proposed removal of private beds from NHS hospitals and the findings of studies such as Cartwright's investigation of general practice in 1977 which showed evidence of a weakening service orientation on the part of GPs (Cartwright and Anderson 1979). Gradually, under pressure from multiple sources, the public image of the medical profession was transformed from a bastion of altruism to simply another, if uncommonly powerful, vested interest.

Armstrong (1990) suggests that all government bids to reform the NHS from the mid-1960s onward can be seen as attempts to curtail the influence of the medical profession over health resource allocation. However, the consensus among commentators (Haywood

and Alaszewski 1980; Ham 1981; Elcock and Haywood 1989; Hunter 1991) is that the various direct measures taken, such as the introduction of general management following the *Griffiths Report* and attempts to involve clinicians in a variety of budget management initiatives, had only limited effects. In a 1989 review of the impact of general management, Harrison (1989 p38) concluded that there was little sign of change in doctor-manager relations:

> *"They continue to inhabit a shared culture of medical autonomy in which only rarely do managers challenge clinicians."*

Until 1989 management opportunities to influence the quality, as distinct from the management, of medical activity were very limited indeed, being confined to disciplinary procedures for dealing with cases of serious incompetence and, in primary care, sanctions for failure on the part of GPs to maintain basic standards of premises and equipment or honour their terms and conditions of service. The only government attempts to influence clinical practice directly were in the area of prescribing, through the introduction in 1984 of the limited list and, in general practice, the use of the PACT (prescribing analysis and cost data) system for monitoring individual practitioners' prescription activities. In contrast to the growing preoccupation with quality in every other aspect of the health service, the quality of medical practice was still seen as an entirely professional matter and was left in the hands of the General Medical Council and the various Royal Colleges.

Nevertheless, during the 1980s, a variety of developments combined to make it likely that some mechanism of quality assurance for doctors would soon be introduced. First, there was growing evidence of unexplained variations in medical work, for example regarding hospital admission rates for common surgical operations such as prostatectomy, tonsillectomy and hysterectomy (McPherson et al 1982). With regard to primary care, considerable variations were identified between GPs in relation to prescribing habits, investigation rates and home visits (Crombie 1984; Metcalfe 1985) and referral rates. For example a study by Wilkin and Smith (1986) found rates of referral varying from 1 to 24 per 100 consultations. In addition, the use of performance indicators developed by the Operational Research Division of the Department of Health and Social Security generated information about the relative performance of different health authorities and hospital specialties. Although performance indicators were dominated by measures of resource input such as staffing and beds, the variations in activity they revealed - for example in

length of stay in hospital for hernia and appendicectomy patients (Morgan 1988) and in the annual operating rates of individual surgeons (Yates et al 1985) - inevitably raised questions about how the quality of care might also vary. In a review of the evidence on such variations, Ham concluded that at least some of the variation was attributable to differences in individual clinical practice (Ham 1988).

Routine activity data were also used to generate information about variations in outcomes of health care. In 1986, the Centre for Health Economics in York published an analysis of variations between health authorities in standardised mortality ratios following a range of different hospital interventions (Kind 1986). This coincided with reports of huge variations between districts in potentially avoidable deaths from conditions such as stroke, cervical cancer and tuberculosis (Charlton et al 1983). Besides these statistical data, a number of well-publicised arguments about clinical competence at an individual level were also taking place, such as the investigation into the work of the obstetrician Wendy Savage (Savage 1986) and the debate about the fallibility of medical diagnosis (Hobbs and Wynne 1987) at the time of the judicial enquiry into child abuse in Cleveland.

At the same time, the gradual demystification of medicine and the developing consumer orientation, reflected in the creation of organisations such as the College of Health, was encouraging self-help groups and pressure groups (such as the Association for Improvement in Maternity Services) to take more proactive approaches to informing users about quality of care and to publicise information about substandard services. Thus issues of clinical quality entered the public domain to a much greater extent than previously and the growing evidence of variation and possible fallibility in clinical practice became part of the public debate.

Developing public interest in the quality of medical practice was reflected in changing views within the medical profession itself. In its evidence to the Royal Commission on the National Health Service in 1977, the British Medical Association (1977) denied the need for any further supervision of a qualified doctor's standard of care. The Commission's own conclusion, as noted in its final report, was that it was not convinced that the profession regarded the introduction of audit or peer review of standards of care and treatment "with a proper sense of urgency" (Merrison 1979). However, a survey of 33 national specialist bodies less than ten years later showed a general acceptance of

professional responsibility for, and numerous initiatives towards, quality assurance (Shaw 1986). In general practice, the 1979 conference of local medical committees adopted the principle of medical audit by peers and continued to pass a series of resolutions throughout the 1980s supportive of clinical audit.

The change in medical attitudes reflects a mixture of idealism, pragmatism and defensiveness in the face of changing public expectations and government interest in increased professional accountability. On the one hand, demonstrable commitment to maintaining and improving clinical quality was increasingly acknowledged as a basic component of professionalism in its own right. On the other, such a commitment was seen as the best means of protecting the profession against what was perceived to be a growing threat of malpractice suits by members of the public. Perhaps most significantly, taking the initiative in this area voluntarily was regarded as the best strategy for limiting government interference and retaining internal control of what was felt to be an essentially professional task. (See, for example, in Table 1.1, the Council of the Royal College of General Practitioners' rationale for developing its Quality Initiative, which was launched in 1983 with the objective of making clinical audit an integral and effective part of the professional lives of general practitioners in every general practice in the UK within ten years.)

**Table 1.1: Reasons for the launch of the Royal College of General Practitioners Quality Initiative in 1983 (Irvine 1989)**

* Doctors' willingness and ability to look openly and critically at the quality of their own work was regarded as fundamental to good clinical practice and seen as the essence of being a professional person.

* There was a need to deal with the problem of the wide variations in standards of care in general practice which had persisted since the NHS began.

* In the emerging consumer world there was a need for general practice to become more responsive to the people it served if it was to survive as the near monopoly supplier of primary medical care in the UK.

* Recognising that general practitioners would have to become more accountable in the future, it was preferable that the balance of responsibility for exercising such accountability should lie with doctors and their peers and patients rather than with the NHS through the doctors' contract.

* Practices which could give reasonable guarantees on quality of care should be better placed in future to secure the appropriate resources for patient care than practices which could not.

By the late 1980s, some parts of the medical profession already had extensive experience of formal quality assurance exercises set up, for the most part, by the Royal Colleges. In anaesthetics and obstetrics, confidential enquiries had been established on a national basis to study maternal, infant and perioperative deaths (UK Departments of Health 1991; Department of Health 1990a; Campling et al 1990). Besides the Quality Initiative, the Royal College of General Practitioners also developed and disseminated methods of quality assessment (Schofield and Pendleton 1986) and a wide range of other audit and quality activities were being pursued in general practice beyond the College's auspices. The nature of these last activities is discussed in more detail in Chapter Two. Those who participated in such projects generally felt positive about the experience. Involvement was, however, patchy and unsystematic and there was no coherent strategy of quality assurance for the medical profession as a whole.

While doctors' clinical activity had so far been left out of NHS initiatives concerning service quality, pressure was increasing, for example from the National Audit Office, to make good this omission (National Audit Office 1988). If the logic of keeping costs down and increasing efficiency by addressing issues of quality in the NHS was correct, there was no rational reason why clinical activity should remain exempt from this process. The government's interest in developing an internal market for health care also increased the political need to establish effective quality control mechanisms throughout the system to deflect charges of creating a two class system (Pollitt 1990).

Perceptions that the time was ripe in terms of public and professional expectations and governmental strategy for taking some initiative in this area were reinforced both by the government's own recent experience and by international developments. In Britain, with the 1988 Education Act, the government had already demonstrated its capacity to tackle other professions on issues of quality by introducing teacher appraisal in schools and for academic staff in the universities. From the United States, where the operation of the Federally-funded reimbursement schemes (Medicare and Medicaid) had been linked to performance monitoring through peer review of case notes since the early 1970s, there was evidence from almost 15 years of experience that state-led systems of medical audit could be run successfully. In Europe in 1985 the World Health Organisation had exhorted all member states to introduce effective mechanisms for ensuring the quality of patient care within their health systems by 1990 (WHO Regional Office for Europe 1985).

When all these factors are taken together it can be seen why Moores, writing in 1988 in anticipation of the outcome of the Prime Ministerial Review of the NHS, concluded that "an inexorable and unstoppable move towards some form of medical audit" was already underway (1989 p325). With the publication of the white paper *Working for Patients* in 1989, in which the participation of all doctors in regular and systematic audit was defined as "a fundamental principle of the review", that conclusion was shown to be correct (Secretaries of State 1989a).

## Chapter Two

## MEDICAL AUDIT: CONCEPT AND USE IN GENERAL PRACTICE

This chapter begins by describing what medical audit is and the principles and assumptions that underly it. The place of audit in the range of professional and managerial activities concerned with assuring the quality of general practice is then considered and the practice of audit by GPs is discussed in terms of types of investigation, sources of data, methods of working and the uses to which it has been put. The chapter concludes with a brief review of what is known about the effectiveness of general practice audit in achieving improvements in patient care.

### *The concept of audit*

Audit is a method of quality assurance which is increasingly being used by those involved in providing health care. To health professionals, audit offers a systematic framework for investigating and assessing their work and for introducing and monitoring improvements. There are a number of different aspects of health care and health service practice which could potentially be subject to audit. Distinctions have been drawn between different types of audit in terms of the focus of the activity and the personnel involved. According to Shaw and Costain (1989) "medical" audit involves the review of activities initiated directly by doctors, while "clinical" audit covers all aspects of clinical care including that provided by nursing and paramedical staff. "Organisational" audit refers to investigation of aspects of practice such as appointments systems which are regarded as primarily administrative even though they may involve consideration of clinical issues. "Contractual" audit is concerned with such issues as adherence to terms of service and is more often regarded as part of managerial monitoring.

The process of carrying out an audit involves a characteristic sequence of events which include:

* defining standards, criteria, targets or protocols for good practice against which performance can be compared;
* gathering systematic and objective evidence about performance;
* comparing results against standards and/or among peers;

* identifying deficiencies and taking action to remedy them and;
* monitoring the effects of action on quality.

Audit is conceived of as a cyclical activity, on the assumption that reviews of this sort should be carried out continuously. There is some debate about whether it is essential to carry out the stages of audit in the order given above (in practice, definition of standards often follows the gathering of evidence), whether additional stages should be added and whether all stages must be completed to warrant the term audit (much so-called audit starts and ends with data collection). Such technical issues apart, however, the actual process of audit is relatively uncontested. But little else about audit is so clear or generally agreed.

Since the word "audit" began to be used in the context of evaluating medical work in the UK in the 1970s there has been terminological confusion about what it signifies. In part this derives from its association with accountancy, and uncertainty about how far the connotations of numerical review by an outside investigator are intended also to apply in health care. Misunderstandings also arise from the loose and inconsistent use of a wide range of terms, including audit, as interchangeable synonyms for a variety of approaches to reviewing clinical quality with purposes ranging from self-education to monitoring of contractual conformance. (To illustrate this point, Shaw generated a list of 96 phrases that either had been or could be used to mean review of health care (Shaw 1980)). Furthermore, medical audit means different things in different countries. In the United States, where the concept was first developed, medical audit has a narrower focus in terms of method (primarily record review) than in this country and is perceived as a method of external control in contrast to the British emphasis on professional self-regulation (Jost 1992).

Attempts to untangle the semantic confusion have focused on defining the differences between audit and other quality assurance activities on a number of parameters including the frequency and focus of the activity, who participates in it and what is done with the findings. For example Stone (1990) devised a taxonomy which distinguished between the six activities which he regarded as collectively comprising the "intelligence gathering arm of quality assurance" according to the professional perspective they reflect (clinical, epidemiological, or managerial) and the extent to which they are ad hoc or routinely

carried out. On this basis he defined as *review* the process of critical reflection used by clinicians wishing to assess their own (or their peers') performance and as *audit* the activity of review when it is conducted on a continuous and routine basis. Both review and audit were characterised as usually clinically based, descriptive and voluntary. Under the epidemiological heading he described one-off assessment of the impact of a service on indices of health as *evaluation* and routine evaluation as *surveillance*. The terms *appraisal* and *monitoring* were used for ad hoc and ongoing data collection and analysis by management in relation to health care delivery. Stone summarises audit, surveillance and monitoring as routine processes which share a common objective of continuous quality assessment but are distinguished by the nature of their feedback loops which are to clinical, public health and administrative action respectively.

Shaw sought to clarify the relationship between audit and other forms of scrutiny of the quality of medical care by placing them in a framework with two dimensions - internal/external and clinical/non-clinical. He identified a continuum between internal, clinical, medical audit and external, non-clinical inspection. The former he characterised as voluntary, educational and without sanctions, the latter as statutory and regulatory, with implied sanctions (Shaw 1980). Other clinical commentators have endorsed this model, seeing the absolute separation between audit and external monitoring and the emphasis on audit as voluntary, educational and internal to the medical profession as practical essentials for achieving the objective of better patient care (Marinker 1986; SCOPME 1989b). For example, Pringle identifies safety as a prerequisite for doctors auditing areas where they feel their care may be lacking and sees safety as dependent on a non-threatening environment free from contractual penalties, denigration or litigation (Pringle 1990).

Table 2.1 lists the features of audit about which there is general consensus and compares these to the principles of the two contrasting approaches to quality assurance described earlier. As may be seen, audit is a curious hybrid of the traditional and more recent approaches. Theoretically, in terms of objectives, personnel involved and actions taken where faults are found, the positive and participative tone of audit sets it firmly within the TQM model of continuous quality improvement. In practice, however, personal belief and confidence in managerial commitment to such a conciliatory and non-judgmental philosophy is less than robust. A continuing fear among clinicians is that audit will

**Table 2.1: Principles of audit and approaches to quality assurance**

| | *Traditional quality assurance* | *Audit* | *Total quality management* |
|---|---|---|---|
| *Objectives* | To avoid substandard practice | To assess practice and to introduce and monitor improvements | To improve practice |
| *Who is involved?* | External inspection | Self-assessment | Self-assessment |
| *Why do problems occur?* | Individual failure | Individual or system failure | System failure |
| *How are problems dealt with?* | By removal or sanctions | By locating the cause and taking positive remedial action | By locating the cause and taking positive remedial action |
| *How are issues identified and standards defined?* | By experts | Not specified | By customers |

reveal shortcomings in their own practice (rather than opportunities to improve the system) and that if knowledge of these falls into the wrong hands (i.e. those of managers) it will be used against them. The pervasiveness of this view is reflected in the widespread concern among clinicians about the need to keep audit results confidential (Berwick 1989; Berwick et al 1992) and in the anxieties expressed by individual practitioners about how their self-esteem may be threatened by what audit may reveal about their failings (Richards 1991; Black and Thompson 1993).

There is one other important way in which audit remains firmly allied to the more traditional approach to quality assurance, that is in the identification of problems for study and the standards against which practice is audited. While there is nothing in the technique of audit itself which says how topics should be chosen or whose views should be consulted in determining standards, in practice these are generally regarded (at least by most clinicians) as matters for clinicians to decide on the basis of their specialist knowledge and expertise. Although effort may be made to take account of what patients think, scepticism about their capacity to make valid judgments about the quality of clinical care means that there is no question of regarding their views as paramount. While user-centred audit does exist - the College of Health's *Ask the Patient* project (1991) is

one example of audit in which the services provided by a general practice are evaluated entirely against a quality agenda set by its patients - patients or users are rarely so fully involved. Most of the time, patients are used in medical audit as just another source of information (Hughes and Humphrey 1990).

### *The role of audit in general practice quality assurance*

Quality assurance in general practice involves a wide and growing range of statutory and voluntary, formal and informal activities. Table 2.2 shows those activities for which the medical profession and health authorities are currently formally responsible. As may be seen, the professional dimension is primarily concerned with the promotion and confirmation of professional competence in educational terms. Management activities focus in contrast on inspection and monitoring of resources, premises, systems and clinical activity. In both cases, assessment is carried out externally. Failure to meet basic standards or obligations invokes sanctions or exclusion while the pursuit of quality beyond these basic requirements is encouraged by incentives in the form of financial benefits, enhanced status or greater autonomy. (It should be noted, however, that many GPs regard the financial arrangements introduced with the 1990 contract which involve payment for achieving targets or providing particular types of care as a means of forcing them to work in certain ways to retrieve income which was and should have remained part of their basic payment.)

In addition to the activities listed in the table, many GPs and practices participate in a wide range of other informal and voluntary quality related pursuits. At a personal level these include: involvement in professional education as teachers; participation in research as initiators or subjects; involvement in guideline development and standard setting; development of information technology, for example through participation in general practice computer clubs; and extension of clinical skills and activities through acquiring qualifications in other medical specialties and undertaking clinical assistantships.

At the practice level, development activities which contribute to quality improvement include: seeking external accreditation by independent bodies such as the British Standards Institute which assesses practice office procedures against BS5750 quality standards; participation in the King's Fund organisational audit programme which

**Table 2.2: Formal professional and managerial methods of assuring quality in general practice**

| | *Assessment* | *Status* | *Sanctions* | *Incentives* |
|---|---|---|---|---|
| *Professional methods* | | | | |
| Vocational qualifications | JCPTGP | Legal requirement to practice as GP principal | - | - |
| Maintenance of basic professional standards | GMC | Legal requirement to practice as doctor | Disciplinary sanctions, suspension or striking off | - |
| Continuing professional education | Regional Adviser | Optional | - | Postgraduate Educational Allowance |
| Training practice status | Regional Adviser/ JCPTGP | Optional | - | Training allowance and professional status |
| Membership/Fellowship of RCGP | RCGP | Optional | - | Professional status |
| *Managerial methods* | | | | |
| Monitoring of compliance with GP Terms of Service | FHSA Service Committee | Contractual requirement for practice in NHS | Withholding of investment, withdrawal of staff, legal action | - |
| Monitoring of GP prescribing | PACT | Routinely occurs | "High cost" practices must discuss with FHSA Prescribing Adviser | - |
| Targets for cervical cytology and child immunisation* | FHSA | Optional | - | Financial rewards |
| Approval of chronic disease management and health promotion arrangements* | FHSA | Optional | - | Financial rewards |
| Accreditation for child health surveillance*, minor surgery* and maternity services | FHSA | Optional | - | Financial rewards and opportunities to expand practice |
| Granting of fundholding status* | RHA/FHSA | Optional | - | Financial rewards and increased influence over patient care |

KEY. * applies since introduction of new GP contract in 1990 (Secretaries of State 1989b)

provides a framework for continuous developmental review of organisational aspects of the practice including management arrangements, staff development and education, information systems and standards covering patients' rights and special needs (Blakeway-Phillips 1993); receiving facilitation, for example through the Oxford Heart Attack and Stroke Project which provides facilitators to help practices set up screening programmes, train staff and audit performance (Fullard et al 1984); participation in team building activities such as the Health Education Authority's Primary Health Care Team Workshop Strategy in which primary care teams spend two and a half days away from their practices working out their own detailed plans for prevention and health promotion (Spratley 1990); development of internal management and organisational initiatives involving, for example, use of the annual report as a basis for setting objectives (Keeble et al 1989) or developing a practice team manifesto (Adelaide Medical Centre 1990); and involvement in needs assessment and service planning through initiatives such as the community oriented primary care approach which has recently been developed in five pilot sites in Britain, again under the auspices of the King's Fund. In addition an increasing number of practices are becoming involved in service development at a wider level through involvement in fundholding and non-fundholding purchasing groups and voluntary GP forums such as the Towards Coordinated Practice project in Sheffield in which practices collaborate to monitor the quality of services their patients receive from hospitals and other providers (Crawford 1992).

Almost every one of these activities does or could involve audit, either as a component, complement, precursor or consequence. For example, audit is regarded as an important professional skill to acquire and a valuable educational tool (Savage 1991). As such, it has become a regular feature of continuing professional education, both as a subject of study and a vehicle for learning, and audit training counts as an appropriate activity for receipt of the postgraduate education allowance (PGEA).[1] Competence in audit will become part of the summative assessment for general practice vocational training in September 1996 and is already part of the syllabus for RCGP membership.

[1] The PGEA scheme was introduced as part of the 1990 GP contract. Under the scheme GPs can claim an annual allowance of £2025 for participating in 25 days of PGEA accredited courses over a five year period in the areas of health promotion, disease management and service management.

Audit can also be seen as an integral part of practice management and service planning. Irvine and Irvine (1991p.3) have described the relationship between audit and management in the following terms:

> *"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."*

In their view, audit is best regarded as a single stage in the management cycle of planning objectives and setting standards, organising and allocating responsibilities, motivating the team, implementing plans, auditing the outcome and identifying needs which every practice should engage in regularly.

In contrast to its relationship to education and management, audit is not regarded as a research activity itself. As Jones and Spencer (1993) have pointed out, research and audit have different purposes. Research involves the quest for new knowledge while audit incorporates that knowledge into a process aimed at improving care. While research seeks generalisable results, the aim of audit is to incorporate research findings into local activity. Research and audit methods also differ, though both activities require analysis of accurately collected information. Research methodology tends to control for extraneous factors while audit tends to be naturalistic and to reflect the realities of clinical practice. Research questions may be answered by a one-off study, while audit is a continuous activity. Despite these differences, however, audit and research are closely linked in a number of ways. These have been summarised by Black (1992 p.361) as follows:

> *"Research provides a basis for defining good-quality care for audit purposes; audit can provide high-quality data for non-experimental evaluative research; research into the effectiveness and cost-effectiveness of audit is needed to establish the value of different interventions; and research needs to be audited to ensure high-quality work is performed."*

In general practice, as in other areas, audit is needed to assess the extent to which accepted research findings are actually being implemented and the findings of audit may well identify new questions for research.

As will be discussed later, audit is not a contractual requirement for general practitioners,

although it is strongly encouraged. Nor is participation in audit a formal requirement for inclusion in the health promotion banding system, obtaining FHSA support in the form of extra practice staff or other resources, or getting approval for fundholding status. However, practices seeking such approval or support are increasingly finding that the information they need to defend their claims, prepare their business plans or operate their funds is hard to obtain without doing audit. Equally, audit may be needed to help a practice understand why it is failing to reach its immunisation targets and to identify what changes it should make.

Thus, even without the policy on audit which is the subject of this thesis, there are a variety of longstanding, and some more recent, reasons for general practitioners concerned with their own professional development, the wellbeing of their practices or the quality of the care they provide to become engaged in audit. Many have done so, though sometimes without being aware that that was what it was called, since well before 1989 when "audit" became a buzzword, pressure to engage in it became official and the support systems to be discussed later were introduced.

*Methods of audit in general practice*

A review of the published literature on general practice audit was undertaken by the author in 1990 shortly after the new policy on audit was introduced, to clarify what types of audit activity GPs were involved in, how they were working and what sources of information were being employed (Hughes and Humphrey 1990). This review identified a number of studies which conformed relatively well to the audit process described earlier, in that all components of the cycle were followed through including the setting of standards. These included audits on a diverse range of subjects such as the diagnosis and management of chronic illnesses such as epilepsy and diabetes (Cooper and Huitson 1986; Day et al 1987) and acute conditions such as pelvic inflammatory disease (Eynon-Lewis 1988), the identification and management of patients with raised blood pressure (Mant et al 1989), the support of carers of patients with dementia (Philp and Young 1988) and the use of an antibiotic formulary (Needham et al 1988). Such studies were used to provide information about the extent of adherence to a protocol and the level of performance achieved, to identify problems and show where change was necessary. Some of these projects were undertaken by individual practices. Others, such as the audit of

cervical cytology progammes undertaken by the Vale of Trent Faculty of the RCGP (Wilson 1990) were initiated by, and involved working in, a larger group of peers. In most cases GPs and/or practice staff were involved in collecting and analysing their own data but there were some examples, such as the Oxford-based Rent-an-Audit, where an outside team was recruited to carry out the audit and feed back the results (McKinlay 1987). Many of these audit projects depended on the collation of information from existing data sources (see Table 2.3), but in some cases information was also collected directly from patients or practice staff.

**Table 2.3: Sources of data for audit in general practice**

| | |
|---|---|
| *Within practice* | |
| All practices: | Patient records<br>Appointments books<br>Referral and discharge letters |
| Some practices: | Age/sex and disease registers<br>Information from death certificates |
| *Provided by the FHSA* | |
| To all practices: | Quarterly updates on registered practice population<br>Financial statements based on item of service claims |
| To all practices in some districts: | More detailed information from registration data with averages for comparison |
| *Provided by the Prescription Pricing Authority* | |
| To all practices: | PACT sheet every three months |
| *Specially collected information* | |
| For particular projects: | Observation in practice<br>Interview or questionnaire data from patients, carers, practice staff etc.<br>Practice activity data<br>Data from other organisations e.g. hospital notes |

In addition, there were many reports of projects which might be classed as audit to the

extent that they involved systematic self-scrutiny of practice with the aim of improving patient care, but which did not conform to the accepted process in other ways. These included numerous examples of "case analysis", involving the careful consideration of one or more cases of a particular event, such as unplanned pregnancy (Metson 1988), a specific symptom, such as abdominal pain (Edwards et al 1985), an aspect of care, such as a hospital referral (Emmanuel and Walter 1989), or a doctor-defined characteristic, such as the "heartsink" patients described by O'Dowd (1988). These studies differed from the audit projects described above, in that most of them did not involve comparison against agreed clinical standards or management protocols. Rather, their purpose tended to be more exploratory - to find out about what was going on in a particular area of practice, to examine the appropriateness of decisions or the general quality of care for certain patients or, in cases where problems had already been identified, to find out what had gone wrong and thus help prevent recurrence. Some of these studies were undertaken by individual practitioners, others extended outside the practice to include informal carers, hospital colleagues and social services staff. While they did not necessarily require any further information beyond that routinely available in patients' records, many of them involved extraction and collation of data from different sources.

A further activity identified in the review was that of "practice activity analysis" (PAA), which involves the prospective collection of frequency data about easily measurable aspects of practice work such as prescribing of particular drugs, home visits or referral rates. The information is recorded on specially produced forms for a specified period or until a quota of patients in a certain category is reached. Data from participants are then pooled and analysed to produce comparable information about individual and group performance. Each participant receives summary statistics of his or her performance, with the group mean for comparison. PAA exercises do not count as audit in themselves, in that the purpose of such studies is to provide GPs with facts about their own performance and to show up variations in practice but not necessarily to bring about change. Some practices had set up their own PAA studies, such as the study of out of hours workload reported by Pitts and Whitby (1990), in other cases the family practitioner committee was coordinating a scheme for practices in its area (Peter et al 1989). In addition, the RCGP Birmingham research unit which had developed the technique of PAA in the first place was providing a service to practices throughout the country (Buckley 1989).

Finally, there were some examples of practitioners obtaining insights into the quality of their practice by obtaining feedback from others who had observed or experienced their care. The "What sort of Doctor?" initiative developed by the RCGP in the early 1980s had led to many GPs visiting each others' practices on a voluntary and reciprocal basis for the purpose of assessing their own work (RCGP 1985). Practice visits lasted about a day and included observation, discussions with staff, inspection of records, videotaped consultations, an interview with the doctor and a self-completed questionnaire. Criteria for good practice included "professional values", accessibility, clinical competence and ability to communicate. Acceptable levels of performance were not, however, specified. Besides seeking the views of their peers, some GPs had also attempted to explore patients' perceptions of their care. Most such studies involved questionnaire based surveys administered either by the practice itself or by the community health council at the practice's request (Williamson 1989), but there were also some reports of less directive studies using interview techniques in which the patients were left to define the issues and events that were important (Gau et al 1989). These studies tended to focus on interpersonal and organisational aspects of care rather than technical or clinical competence.

As mentioned above, the review reported here was based on published literature only. It is not possible to judge how true an impression it obtained of the whole range of unreported audit activities taking place in general practice. Nevertheless, the studies mentioned do provide some indication of the experience and preoccupations of GPs who were already active in audit at the time of the NHS reforms.

***Impact of audit in general practice***

Shaw suggests that the purpose of audit is to identify opportunities for improvements in the quality of medical care, medical training and continuing education and the effective use of resources and to ensure that these improvements are implemented (Shaw 1989). It is widely assumed that, if undertaken properly, audit has the potential to deliver substantial benefits to patients in terms of more appropriate and higher quality care, better educated and more highly skilled doctors and better organised services. These benefits may follow directly from changes introduced following audit of a specific area of care or aspect of service organisation. Alternatively they may arise as an indirect consequence

of the activities involved in doing audit. For example, part of an audit cycle might involve the agreement of a protocol for managing a particular condition. Meetings convened for this purpose also provide the opportunity for discussion and information sharing in related areas. The result may be better teamwork, generally improved communication between staff and consequently better organised care for patients in a variety of respects over and above those specifically addressed in the audit (Moulds 1986). In addition, besides the benefits deriving from particular audit projects, the development of a more general "audit culture" involving regular review of policy and practice and systematic attention to patients' views may produce beneficial changes in participants' attitudes, including a greater degree of consciousness about their activities and a more critical approach to their profession (Grol et al 1988).

*Can audit work?*

Most attempts to assess the effectiveness of audit have concentrated on looking at the improvement achieved as a direct result of changes introduced. Sometimes changes in outcomes for patients are directly measurable, but more often benefits are imputed from changes in the structure or process of care. The more indirect or unanticipated side effects of audit are harder to take account of and have been largely overlooked in considerations of effectiveness, as have the more loosely defined consequences of introducing an audit "culture".

There are a number of published reports of audits undertaken in general practice where substantial improvements in performance have been noted following the introduction of changes in practice as a result of audit. These include audits of preventive measures (Fleming and Lawrence 1983), epilepsy care (Taylor 1987), cervical cytology rates (Wilson 1990), recording of risk factors for cerebrovascular and coronary heart disease (Maitland et al 1991) and of childhood accidental injury information (Marsh et al 1995). In addition, in the past five years many medical audit advisory groups have reported cases of successful audit in their annual reports and newsletters. A brief review of such local publications carried out in 1993 by the Eli Lilly National Clinical Audit Centre produced over thirty examples of audits where improvements were clearly shown and the authors reported that they could "undoubtedly" have collected more (Cooper and French 1993).

A study of 71 of the "best" audit projects submitted by general practices in Staffordshire reported that 58 of these had led to changes being made. Fiftythree of the practices had subsequently reviewed the effects of these changes and 35 of them reported that the required improvements had been achieved (Chambers et al 1995). A study of the impact of audit on general practitioners' patterns of prescribing found a broad consensus among FHSA medical advisers that audit of prescribing had led to better quality patient care, particularly in respect of repeat prescriptions (Richardson et al 1993). Humphrey and Hughes' (1992) exploration of the links between audit and service development in primary care found evidence of audit improving the care provided by individual practitioners and practice teams and making important contributions to service development at district level.

However, the major limitation of all these examples as evidence of the effectiveness of audit is that they are uncontrolled, descriptive studies, many of which include some element of subjective assessment of improvement by those with a stake in the audit. Even where improvements have been objectively demonstrated (for example, rates of immunisation being raised) it cannot be assumed that the benefits are attributable to the audit process alone - other changes such as national trends in care or improved record-keeping may also contribute. As Buxton (1994) has observed, more rigorous studies of audit in any area of health care are very rare, although some do exist. The one such study that has been undertaken in British general practice is the North of England Study of Standards and Performance in General Practice (North of England Study 1992). This study involved 92 GP trainers over a period of five years in developing methods for setting clinical standards for the management of common childhood conditions and assessing their performance against these standards. Using a before and after design (with a replicated Latin square) the study was able to demonstrate significant improvements in clinical practice among the doctors involved. Perhaps because of its exceptional methodological thoroughness, this study is frequently cited as evidence that audit can work in primary care, but the extensive nature of the project in terms of both scale and duration makes it a very atypical example of general practice audit.

To assess the overall impact of an audit, a number of other factors beside the direct and immediate improvement obtained must also be taken into account. These include the durability of the improvement and the extent of any "ripple effect". The limited evidence

available in these areas (which, in general practice, also comes from observational studies of the type already described) is mixed. Where audit leads to substantive changes in the organisation of care or the introduction of a new service it appears that improvements have a reasonable chance of being maintained (Fleming and Lawrence 1983; Taylor 1987; Wilson 1990). However, changes that depend on increased awareness or vigilance on the part of practitioners appear to be less robust. For example, a study of GPs' prescribing patterns following group discussion of data on individual prescribing behaviour found that changes in prescribing occurred initially, but disappeared again within 18 months (Harris et al 1985).

The evidence regarding knock on effects of audit (on comparable areas of practice or on non-participating colleagues) is generally negative. For example, in the North of England Study described above, the participating doctors did not change their practice significantly in any area of work except the one in which they were explicitly involved in setting a standard. Anderson et al (1988) report an audit of digoxin prescribing which resulted in improved record-keeping among the GPs participating in the audit. The results of the audit were discussed with other principals in the participants' practices, but the practice of these colleagues did not change. On a wider level, Humphrey and Hughes (1992) found that the service implications of audits carried out within individual general practices frequently went unrecognised and results were not therefore adequately disseminated to others with a potential interest in the findings.

*Does audit work in practice?*

On the basis of this limited evidence it cannot be concluded with any confidence that general practice audit is an effective means of improving patient care, although it appears possible that in some cases it may produce benefits. What does seem likely, however, is that for every project which successfully completes the audit loop and results in beneficial change there are many others that do not reach that stage. In the review of the literature on audit in general practice discussed earlier it was found that most reported audit projects were simply exercises in describing or measuring aspects of practice. Few of the reports specified what changes were planned or had been introduced as a result of the audit and even fewer contained any indication that the audit had been repeated to assess the impact of the changes (Hughes and Humphrey 1990). In the Staffordshire study reported above, only 71 of the 189 local practices participated. The rest had either never

started or not completed any audit projects. Each of the participating practices submitted its "best" audit, and no information was collected about other audits they might have undertaken. Assuming that these were likely to have been of a lower standard, the authors comment that their findings are likely to have exaggerated the overall quality of the current audit activity in Staffordshire (Chambers et al 1995).

A number of factors have been identified as significant in determining whether audit leads to change (or, indeed, whether it is even undertaken). These include issues of perception, attitude and motivation (Humphrey and Hughes 1992; Kerrison et al 1993), organisational and environmental factors (Chambers and Bowyer 1993; Lincolnshire MAAG 1993), interpersonal and managerial skills (Newton et al 1992; Gabbay and Layton 1992), choice of audit topic (Shaw 1989; Baker 1990; North of England Study 1991), adequacy of audit method and understanding of the reasons for deficiencies identified (Crombie and Davies 1993) and the extent to which audit is systematically integrated into the routine management of care. Identification of the obstacles to carrying out effective audit has led to much improved understanding of the skills, circumstances and resources required to make it work. But knowing what is needed does not, in itself, solve the difficulties presented by audit. As Buxton (1994 p.33) has observed:

> *"Scientific audit is a complex and not easily replicable technology. It is not a technology embodied in hardware or software or purchaseable "off the shelf" but instead has to be created locally. Audit needs to follow a relatively complex sequence of procedures to be effective, and it entails a difficult set of organisational processes....The limited evidence available [suggests] very clearly that the process necessary for good audit is difficult and not easily replicated and maintained over time without appropriate skills and enthusiasm."*

The paper in which these comments were made was an overview of evidence on the effectiveness of audit in the NHS in general, not just in primary care. A detailed consideration of the impact of audit in hospitals and community services is beyond the scope of this thesis but the findings of Buxton's study suggest that the picture in those areas is very similar to that presented above. While he identified several studies where audit appeared to have led to appreciable improvements in the process of care, he also drew attention to the paucity of sound evidence about the effectiveness of audit, the mixed findings of those evaluative studies that had been carried out in a rigorous manner and the uncertainty as to whether initial improvements brought about through audit are sustained over time. Buxton's conclusion was that, while it is easy to share the view that

audit seems *a priori* to be a laudable activity, audit is actually no more obviously beneficial than any unproven drug or procedure. Without more evidence, belief in its value is merely an act of faith. It was on the basis of this "act of faith" that the policy on audit to be discussed in the following chapter was introduced. As will be seen, for those who were believers in audit, the lack of proven effectiveness did not appear to dent their enthusiasm for the introduction of the policy. For the sceptics, however, this was and remained a major concern.

## Chapter Three

## INTRODUCING AUDIT

This chapter begins by outlining the policy on medical audit introduced in the 1989 white paper *Working for Patients*. Reactions to the proposals for audit are then discussed and a number of particular concerns identified.

### *Medical audit in Working for Patients*

The white paper *Working for Patients,* published in 1989, set out the case for major organisational change in the NHS and presented a programme of action to secure two objectives: First, better health care and a greater choice for patients; and second, greater satisfaction and rewards for those working in the NHS who successfully respond to local needs and preferences (Secretaries of State 1989a). Seven key measures were proposed to achieve these objectives. These were:

* *Delegating of power and responsibility as far as possible to local level* to make the NHS more responsive to the needs of patients;
* *encouraging hospitals to become self-governing NHS Hospital Trusts* to stimulate a better service to the patient;
* *enabling the money required to treat patients to cross administrative boundaries* to enable hospitals which best meet the needs and wishes of patients to get the money to do so;
* *creating 100 new consultant posts* to reduce waiting times, improve the quality of service and help cut junior doctors' hours;
* *enabling large GP practices to apply for their own budgets to obtain some services direct from hospitals* to help improve the service to patients;
* *reducing management bodies in size and reforming them on business lines* to improve the effectiveness of NHS management; and
* *ensuring that quality of service and value for money are more rigorously audited* to make certain that all concerned with delivering services make the best use of the resources available to them.

The final proposal specified that arrangements for "what doctors call 'medical audit'"

would be extended throughout the health service, helping to ensure that the best quality of medical care is given to patients. It was stated as a fundamental principle that every doctor should participate in regular, systematic medical audit.

Medical audit was defined in the white paper (p.39) as:

> *"A systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome for the patient."*

It was suggested that doctors and managers require information from audit to enable improvements to be made in services to patients, to plan ahead and to improve quality. Moreover, an effective programme of medical audit would "help to provide reassurance to doctors, patients and managers that the best quality of service [was] being achieved having regard to the resources available."(Department of Health 1989 p.3) The white paper emphasised that the practice of medical audit was essentially a professional matter which required both specialised knowledge of current medical practice and access to adequate medical records. Audit was presented as an educational activity, based on peer review, and one that should be professionally led. However, management involvement was seen as necessary to ensure that an effective system of medical audit was put in place. The government welcomed the various audit initiatives already being taken by the medical profession and proposed to work with the profession to build on what had been achieved. As evidence of its commitment to such cooperation, the Standing Medical Advisory Committee was invited to consider and report on how the quality of medical care might best be improved by means of medical audit. Discussions were also initiated with the Royal Colleges and a central fund was established to support medical audit developments.

The plans for medical audit were elaborated in Working Paper 6 (Department of Health 1989). It was anticipated that approaches to audit would vary between different medical specialities. In particular, the organisation of medical audit in general practice was seen as likely to be less straightforward than in hospitals because care is undertaken in more places and episodes of ill-health are less well defined, records must handle continuing care over periods of years, care more often involves teams and records must therefore be shared and environmental factors as well as the doctor's actions may substantially affect outcome. Detailed provisions for the new advisory groups that were to be

introduced to support medical audit in the hospital and community health services and in primary care were issued in two separate circulars (Department of Health 1991; Department of Health 1990b). These arrangements are summarised in Table 3.1. Regional Audit Committees were also proposed to advise and support the development of audit.

**Table 3.1: Provisions for medical audit in hospital and community health services and in general practice**

| Hospital and community health services | General practice |
|---|---|
| By April 1991, a district medical audit committee (DMAC) to be established in each district chaired by a senior clinician and including representatives of the major medical specialties together with doctors representing the district general manager. (Similar arrangements to be made for each self-governing trust.) | By April 1991, a medical audit advisory group (MAAG) to be established by each family health services authority (see note below) in cooperation with the local medical committee. MAAG to be chaired by a GP and to include not more than 12 members who are medically qualified. The majority of members to be local GP principals. |

**Responsibilities of DMACs/trust audit committees/MAAGs**

* to institute regular, systematic, medical audit in which all practitioners are enabled to take part (MAAGs were given the target of having all practices participating in audit by April 1992)
* to ensure confidentiality of audit results for individual patients and doctors
* to ensure that the patient's perspective is taken into account in the audit programme
* to ensure adequate links between medical audit and local post-graduate and continuing medical education programmes to enable deficiencies revealed by audit to be dealt with
* where audit reveals serious problems related to medical practice, to ensure that appropriate action is initiated and changes result
* to agree with management a programme for audit
* to provide management with regular reports on the general results of the audit programme (for MAAGs this was expected to include an evaluation of the audit exercise itself)

**Responsibilities of DHA/trust management/FHSA**

* to ensure an effective system of medical audit is in place
* to ensure adequate resources are available to support the agreed audit programme

Note: Family practitioner committees (FPCs) were replaced by family health authorities (FHSAs) in 1990. The white paper and other documents refer to FPCs, but the change of name took place before the medical audit policy was implemented. For consistency, the term FHSA is used throughout this thesis.

Both circulars emphasised issues of organisational structure rather than process, and stressed the need for flexibility with regard to the latter:

> *"The detailed practice of medical audit is a matter for the medical professions and will evolve as experience is gained and differ from place to place as a result of local initiatives." (Department of Health 1991 p.3)*

As far as structures and functions were concerned, apart from obvious differences in membership, the main responsibilities of the audit support groups and of management in the two settings were basically very similar. There were, however, some important differences in style and emphasis. The primary care circular was notably less prescriptive than that concerned with secondary care about the expected content of medical audit advisory group (MAAG) reports to management and placed less emphasis on achieving formal agreement over forward plans. The primary care circular also stressed the separation between medical audit and the monitoring function of the family health services authority (FHSA), requiring the latter to develop mechanisms independent of the medical audit system to consider wider issues of quality and to ensure that contractual obligations were fulfilled. In contrast, the hospital circular specified clear circumstances in which the medical audit committees could be asked to become involved in external audit.

Beyond the circulars, there were also several key differences between the two sectors with regard to funding for medical audit and the contractual responsibilities of individual doctors. First, far more money was allocated for medical audit in the hospital and community health services than for primary care. In the first two years, the allocations were £28 million and £5 million respectively. For 1991-2 (the first year of the audit advisory committees and groups) the respective allocations were £48.8 million and £12.5 million (NHSME 1993b). Second, arrangements for distributing the funding differed. Central funds for medical audit in the hospital and community health services were distributed to provider units through regions and special health authorities on a capitation basis (whole time equivalent consultant numbers). In contrast, FHSAs received funding to support primary health care audit in their general allocation. This money was not ring-fenced, but a banding system based on the size of FHSA districts was used to indicate to regions the amount each FHSA should get for audit. The monies allocated for audit were intended to finance and resource the new organisational structures to enable them to develop effective systems of medical audit, but not to fund individual doctors or

practices to do audit. In the secondary sector it was anticipated that costs arising from the development of medical audit would be assessed and considered in future Public Expenditure Surveys. In primary care, likewise, no provision was made to pay GPs for time spent doing audit as it was expected that this activity would appear in the workload survey and then be considered by the Review Body in their deliberations on basic net income.

Finally, the arrangements for achieving the participation of "every doctor" in audit differed significantly between the two sectors. In hospitals, audit was to be included in all consultants' job descriptions and time for audit reflected in locally agreed job plans. Participation in audit therefore effectively became a formal requirement. In general practice, it was initially intended that GPs' terms of service would be amended following consultation with the profession, to include a requirement to participate in medical audit "once satisfactory arrangements to support audit were in place locally" (Department of Health 1989 p.12). Subsequently, however, the commitment to making participation in audit a contractual obligation for GPs was quietly dropped. The view of those involved at the time is that this change of heart occurred because of strong representations from those responsible for general practice in the Department of Health who believed that making audit contractual would send the wrong messages to GPs about its purpose (Field R, personal communication). The feeling was that persuading practitioners to engage in audit voluntarily as part of their professional responsibilities would produce better quality and more meaningful results than if they were forced to do it.

*Reactions to the policy*

Medical reactions to the proposals for audit must be set in the context of reactions to the white paper proposals as a whole, which were generally very negative. There was concern that the proposals failed to address the chronic underfunding of the NHS, despite the fact that the NHS review which led to the 1989 white paper had been set up in direct response to the perceived financial crisis in the NHS (BMA 1989); there were doubts about the need for such a major reorganisation of the system and scepticism as to whether patients would benefit from the changes (Anon 1989); and there was anxiety that so many of the major changes proposed would be introduced untested (Drury 1989). In addition, in primary care, general practitioners were angry about the imposition of the 1990 GP contract (Secretaries of State 1989b) which would link their pay more closely to

performance in certain activities and raise the capitation element of their pay to 60% (Beecham 1989). Findings from a survey undertaken in early 1989 of GPs' reactions to the white paper's proposals reported that more than three quarters of the 2231 GPs replying felt their independent contractor status and clinical freedom would be restricted by the government's proposals and only 11% of respondents believed patient services would see any change for the better (Turner 1989).

Against this background, the reaction to the proposals for medical audit from the Royal Colleges and others speaking on behalf of the medical profession was strikingly positive(SCOPME 1989a and b; Royal College of Physicians 1989; Royal College of Surgeons 1989). A *Lancet* editorial on *Working for Patients* observed that it was "high time that doctors examined critically the outcome of treatment and compared it with performance"(Anon 1989 p.247). In a British Medical Association special report on the white paper, the government's recognition of the importance of medical audit was the one component of the reforms that was explicitly welcomed (BMA 1989). However, the Royal Colleges took care in their publications to reiterate the principles of medical audit as educational, confidential and non-judgmental and to define some of the ground rules that appeared still open to negotiation. For example, the BMA council stated its opposition to making participation in audit a contractual obligation for general practitioners (BMA 1989).

A combination of reasons may account for the acceptability to the medical leadership of the government's audit policy. First, it was generally accepted that some strategy to ensure the quality of clinical care was needed and would soon be introduced. It had been feared that this would involve inspectorates or other forms of external review. In the event the proposals were far more moderate and the Department of Health took care to emphasise the positive aspects of medical audit as against other existing quality control mechanisms (such as the General Medical Council's disciplinary procedures and the law) which were "by and large, threatening top-down mechanisms designed to weed out the grossly aberrant performers" (Macpherson and Mann 1992 p.91). Second, the various documents and circulars relating to medical audit were extremely circumspect about the wording of the proposals, avoiding provocative terms such as "mandatory" or "compulsory" in relation to participation in audit and making no mention of penalties for those who resisted. Third, some potentially controversial issues were fudged by the use

of apparently contradictory statements in different places, for example emphasising the educational and professional focus of audit while at the same time requiring reports to management on the general results. Finally, problems were avoided by leaving key terms undefined and details of implementation deliberately vague. Pollitt (1993b) suggests that the profession's representatives were relieved to be presented with an arrangement which gave the Royal Colleges earmarked funds and a mandate to develop new arrangements for professional self-regulation and also pleased to find at least one area of the white paper's proposals with which they could agree.

Not all clinicians, however, were reassured by the apparent benignity and flexibility of the proposals. Writing from primary care, Metcalfe (1989 p.1293) pointed out that GPs, FHSA managers and government were all likely to have different intentions in relation to audit:

> *"The government will hope to find out what it is getting for its money; general practitioners will want to close the gap between what they think they are doing and what actually gets done; and managers will want to use audit to drag the tail of the caterpillar towards the head."*

Evasion of detail about what was really intended might enable the policy to gain widespread support in the short term - with each group reading into it what they wanted - but "a programme with three different goals is fraught with problems". Metcalfe's concern about the vagueness of the policy was echoed in a series of *Lancet* articles by various specialists invited to comment on the audit policy. All had positive things to say about the benefits of audit in principle, but there were many doubts about how the policy would work in practice - was the committee structure too bureaucratic? would there be adequate time for audit? could confidentiality really be maintained? - and some suspicion about the possible covert purposes of the policy. As one commentator (Godfrey 1989 p.606) put it:

> *"Will doctors in one district be sacked or take a cut in salary when they cannot achieve something as fast and as cheaply as their neighbours in another district?"*

Or might audit serve as a diversionary device to paper over the cracks caused by insufficient resources being directed at a growing demand (Fairbank 1989)? Nevertheless, the general tenor of these articles was cautiously approving:

> *"Two cheers for Paper 6 and medical audit. The third will come if and when the scheme has the intended effect."(Lilleyman 1989 p.546)*

Among hospital doctors and GPs on the ground, attitudes were also very mixed. In an

interview study carried out in four English district general hospitals in 1991, most doctors accepted the need for audit but there was suspicion about the motives behind the government's encouragement and anxiety about what might be done with audit findings. Many of the respondents saw practical difficulties in doing audit and there was some scepticism about its effectiveness (Black and Thompson 1993). A questionnaire survey of 317 GPs in Leeds carried out in 1990 reported that 65% thought medical audit would be a good way of improving their patients' care, but 54% expressed concern over possible difficulties in undertaking it (Webb et al 1991).

Outside medicine, the concessions to medical sensitivities that helped achieve the profession's endorsement were seen by some commentators as significantly undermining the policy's potential value. Pollitt (1993a) has described the prevailing view of audit in the medical literature with its emphasis on local standards, local and absolute confidentiality and anonymity, voluntary participation and no external sanctions for poor performance as the "medical model" of medical audit. He argues that informal, internal methods of quality assurance of this sort, where management plays no significant role and the results are not made publicly available, are disadvantageous from the perspective of public accountability because they fail the "transparency test" - the nature of the attention given to quality is not monitored and justice is not seen to be done. While acknowledging that the white paper did significantly challenge the "medical model" of audit, insofar as it made medical audit a matter of public policy, put pressure on clinicians to participate and involved management (albeit in a very limited way), Pollitt (1993b) commented that NHS medical audit was still "a rather pale affair" in comparison with the American model of mandatory external peer review backed up by sanctions. And, to the extent that audit remained a private activity internal to the medical profession, the need for greater public accountability would remain unmet. In a similar vein, the Association of Community Health Councils observed that it was difficult to see how patients could have full confidence in a system which involved no lay oversight (ACHCEW 1989).

There was also concern that the emphasis on medical leadership and peer review had led to an overly narrow focus on medicine in the policy as a whole. The new organisational arrangements and new money were introduced specifically to facilitate the development of medical audit by doctors. The white paper contained no directives about participation in audit by individual nurses or other health professionals and these groups did not feature

in the membership of the new audit committees.[2] At a time of increasing recognition of the importance of a team approach in clinical work, the emphasis on uni-professional audit was criticised, by the Director of the Royal College of Nursing among others, as inappropriate and potentially divisive (Hancock 1990; Frater and Spiby 1990; Hughes and Humphrey 1990).

Similar anxieties were voiced by commentators looking at the implications of audit from a management perspective, but their concerns went one stage further in that they challenged the appropriateness of segregating professional audit (whether uni- or multi-disciplinary, medical or clinical) from other quality management initiatives such as resource management and total quality management (Charlwood 1991; Harman and Martin 1992). Observing that "the briefest consideration of how treatment and care is delivered to patients emphasises the interdependence of the individuals and departments that provide it", the Director of the Institute of Health Service Managers argued for the integration of professional audit into a much wider model of cooperative working (Charlwood 1991 p.35).

There were also more fundamental doubts about the wisdom of a policy focusing on the methodology, rather than the purposes, of clinical quality assurance, and concentrating so heavily on one particular approach. The way the objectives of the policy were expressed, there was a danger that doing audit might become an end in itself, rather than merely a means to an end. There was a risk that topics would be chosen for audit because they were easy or interesting to study, rather than because they were necessarily important to patients. Aspects of care for which data already existed would be early candidates for audit, whether or not they were causing major concern. At the same time, important aspects of practice might be neglected entirely because they were not susceptible to audit. And, because of the emphasis on audit over other approaches, important problems might be tackled ineffectually through audit, when they could be dealt with more satisfactorily in some other way (Humphrey and Hughes 1992). These concerns were the more important because of the weakness of the evidence that audit

[2] From 1991 onwards, some separate additional funds were also provided for the development of audit in nursing and therapy, in primary health care dental practice and, to a very limited extent, for pharmacy audit. However, levels of funding were very much lower in these areas.

could be beneficial to patients and the known difficulties of completing the audit cycle effectively. In a vigorous challenge to the policy on audit, Maynard accused the government of profligate expenditure on an unproven methodology, based on an expedient alliance with the medical profession rather than on any real evidence, and argued for urgent evaluation of the costs and benefits of the audit programme (Maynard 1991).

Whatever attitude was held towards the policy in principle, some problems were anticipated in its implementation. These included practical obstacles of time, money and organisation (for GP practices and clinical departments as well as for the new audit committees), the difficulty of motivating clinicians (who might be sceptical, anxious and/or preoccupied with other priorities) and the general shortage of audit skills, technical knowledge, appropriate equipment and useable data. It was also widely acknowledged that the success of the policy would depend on the quality of the dialogue established and maintained between clinicians and managers. Because of the delicate balances involved, things might go either way:

> *"The introduction of medical audit may, in time, be seen as the turning point in quality assurance...This will be achieved if handled sensitively. If [audit] is imposed in a rigid manner, it will become a discredited bureaucratic activity."(Pringle 1990 p.3)*

## Chapter Four

# MEDICAL AUDIT ADVISORY GROUPS: MONITORING AND EVALUATION

This chapter begins by reviewing the scope and findings of studies undertaken to monitor and evaluate the work of MAAGs since their introduction. The purpose and nature of the study which forms the empirical core of this thesis is then described and its role in relation to the other MAAG studies is briefly explored.

### *Evaluation studies*

At the time of the 1989 NHS reforms there was widespread concern about the absence of plans for testing out or evaluating the effects of the major changes which were proposed, and this continues to be regarded as a serious failing. In a recent editorial about the need for evidence-based policy as well as practice, Ham and colleagues (1995 p.71) commented that:

> *"The failure of the government to evaluate the effects of its health care reforms properly at the outset will go down in the history of the NHS as an omission of the highest order."*

The 1989 proposals for audit were no exception to the general rule and there was no built in programme of evaluation. Nevertheless, a number of evaluation studies have since taken place and a large amount of information has been generated about activities occurring under the auspices of the various audit programmes.[3] With regard to secondary care, a review published in 1993 of evaluation initiatives relating to the

[3] Data regarding audit projects undertaken during the first three years of the policy are summarised in four separate reports published by the NHS Management Executive: *Medical Audit in the Hospital and Community Health Services* (NHSME 1994a); *Clinical Audit in the Nursing and Therapy Professions* (NHSME 1994b); *Medical Audit in Primary Care* (Humphrey and Berrow 1994); and *Medical Audit of the Royal Colleges and their Faculties in the UK* (Hopkins 1994). In respect of audit in secondary care and in the nursing and therapy professions, the Department of Health was able to monitor activity systematically because the funding for these programmes was top-sliced and regions collected statistics on all audit projects funded. In contrast, in primary care, the government had no routine access to systematic information on MAAGs or individual audit projects (except those funded through regions from centrally retained audit monies) because MAAGs were accountable to FHSAs and the money to support them was not top-sliced. In this area it was therefore dependent on data from other sources and from specially commissioned evaluation projects.

medical and clinical audit programme found a total of 20 studies carried out for the Department of Health. Most of these focused on medical rather than clinical audit and were dominated by the provider/clinician perspective. There was little formal evaluation of audit programmes above provider level (Walshe and Coles 1993a). In addition, in 1993 the Department of Health commissioned a multi-stranded evaluation of the medical audit programme in the hospital and community health services in England. The project involved a series of separate but interlinked sub-projects, each directed at a different area of the programme and using a variety of data collection methods (Walshe and Coles 1993b). Medical audit in secondary care was also one of the topics studied in the evaluation programme set up by the King's Fund to evaluate the NHS reforms (Robinson and LeGrand 1994).

In respect of primary care audit there was no large scale evaluation programme. Instead a small number of complementary but formally unconnected studies of various aspects of the audit programme were commissioned at different stages by the NHS Executive and several further projects were initiated by independent researchers. These studies are listed in Table 4.1 and will be discussed in more detail below. In addition, primary care audit was one aspect of the 1989 reforms in which some effort was made to pilot the new arrangements before general introduction. Pilot MAAGs were set up in four volunteer districts (Newcastle, Northumberland, Liverpool and Lincoln) in January 1990 with a brief to report after one year. However, there was no coordinated evaluation of the pilot MAAGs, nor were any common criteria agreed for assessment of their progress. When they reported their experiences at a national conference in December 1990, the main finding was that the four districts had gone about their task in very different ways and developed quite contrasting strategies. No conclusions were drawn about the viability of the initiative in principle and no modifications were made to the MAAG brief on the basis of their experience, but two of the districts produced reports on their experiences which were subsequently widely read by other MAAGs (Newcastle upon Tyne MAAG 1990; Liverpool MAAG 1990).

As Table 4.1 shows, a total of 14 studies of the activities and impact of MAAGs were undertaken between 1991 and 1996. In addition to these more formal studies there was also a plethora of information produced by individual MAAGs about their own activities,

**Table 4.1: Studies of activities and impact of medical audit advisory groups**

| *Number* | *Year* | *Researcher(s)* | *Subject* | *Methods* |
|---|---|---|---|---|
| 1. | 1991 | Spencer (1992) | Academic representation on MAAGs | National postal survey of departments of general practice |
| 2. | 1991/2 | NHSME (Humphrey and Berrow 1994) | MAAG funding and audit activity* | National postal survey of Regions and FHSAs |
| 3. | 1992 | Joule (1992) | User involvement in MAAGs | Postal questionnaire to chairs of MAAGs in greater London |
| 4. | 1992 | Griew and Mortlock (1993) | Functioning and organisation of MAAGs with particular reference to training needs and support requirements of MAAG staff* | Semi-structured interviews with MAAG chairs and staff in 15 MAAGs in different regions and postal survey of staff in all other MAAGs |
| 5. | 1992/3 | Humphrey and Berrow (1993) | Development and progress of MAAGs in the first two years* | Semi-structured interviews with MAAG chairs and staff, FHSA managers and medical advisers in 15 MAAGs in two regions |
| 6. | 1992/3 | Houghton and Sproston (1995) | Survey of MAAG funding, audit activity and staffing* | National postal survey of MAAGs |
| 7. | 1993 | Hobbs (1994) | MAAG links with medical schools | National postal survey of MAAGs |
| 8. | 1993 | Lawrence et al (1994) | MAAG methods of rating practice audit activity | National postal survey of MAAGs |
| 9. | 1993/4 | National Audit Office (1995) | Evaluation of patient benefit achieved through the clinical audit programme | Interviews with health care professionals and managers in three regions and analysis of documents |
| 10. | 1994 | Humphrey and Berrow (1995) | Roles and relationships of MAAGs and their managers* | National postal survey of MAAG chairs and FHSA managers |
| 11. | 1994 | Baker et al (1995) | MAAG activity and reported levels of audit activity* | National postal survey of MAAGs |
| 12. | 1994/5 | Baker et al (pending) | The impact of MAAG-led audit* | Postal questionnaire to selected practices in 18 MAAG districts and interviews with MAAG chairs/staff |
| 13. | 1994/5 | Redpath (Kelson and Redpath 1996) | User involvement in MAAGs | National postal survey of MAAGs |
| 14. | 1995/6 | Humphrey et al (Berrow et al 1996) | Study of MAAG involvement in collaborative initiatives with other agencies and health care sectors* | National postal survey of MAAG support staff and follow-up interviews with project stake-holders in 20 districts |

Key: Studies starred* were commissioned by the NHS Executive

**Table 4.2: Focus of investigation of studies shown in Table 4.1**

| | *Evaluation study* | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Focus of investigation* | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| *Structure* | | | | | | | | | | | | | | |
| *Membership* | • | | • | • | • | • | • | | | • | | | • | |
| *Organisation* | | | | • | • | | | | | • | | | | |
| *Resources* | | • | | • | • | • | | | | | | | | |
| *Process* | | | | | | | | | | | | | | |
| *Approach to practices* | | • | | | • | | | | | | • | | | |
| *Type of audit* | | | | | • | | | | | • | • | | | • |
| *Topics of audit* | | | | | • | | | | | • | | | | • |
| *Participants in audit* | | | • | | • | | | | | • | | | | • |
| *Other quality activities* | | | | | • | | | | | • | | | | • |
| *Progress monitoring* | | | | | • | | | • | | • | | | | |
| *Outcome* | | | | | | | | | | | | | | |
| *Involvement in audit* | | | | | | | | | • | | • | | | |
| *Impact on care* | | | | | | | | | • | | | • | | • |
| *Stakeholder satisfaction* | | | | | • | | | | | • | | | | |

both in the form of annual reports to their FHSAs and as publications in the journal *Audit Trends* which was established with Department of Health funding in 1993 specifically to support the development of audit organised by MAAGs.

Table 4.2 shows the aspects of the MAAG programme covered by the different studies. As might be expected, most of the earlier studies concentrated on structural issues while the majority of the later ones were more concerned with the effects of the programme. In terms of objectives, the studies fall into four distinct groups: general, descriptive, quantitative studies of structure and activities; investigations of specific areas of interest

or concern; assessments of MAAG impact; and the qualitative evaluation of MAAGs which forms the core of this thesis. Each group is described in more detail below.

*Studies of structure and activities*

The main purpose of the studies in the first group (studies 2,4,6 and 11) was to ascertain whether the policy was being implemented in accordance with original intent. They include two national surveys of MAAGs, one carried out by the NHS Management Executive itself (findings reported in Humphrey and Berrow 1994) and the other commissioned from the Birmingham MAAG (Houghton and Sproston 1995), and a study of MAAG organisation undertaken on behalf of the Department of Health by two audit support staff (Griew and Mortlock 1993). All three found evidence of gross variation in MAAG budget allocations and in the amounts of money available for audit in terms of notional £s per practice or patient in different districts. These findings are considered in more detail in Chapter Six in relation to the findings of the present study concerning MAAG finance. The studies also collected very basic data on MAAG membership and employment of support staff, methods MAAGs were using to promote audit in their practices and methods of reporting to the FHSA. All the findings showed that, superficially at least, MAAGs were working according to plan. The major activity identified was visiting practices, such that by the end of 1993 approximately half the 13,000 practices in England and Wales were said to have received a visit from the MAAG. In addition, a wide range of other educational and support systems had been established. The fourth study in this group, which was carried out by the Eli Lilly National Clinical Audit Centre, was designed to discover whether MAAGs had fulfilled their remit to "direct, coordinate and monitor" medical audit activities within all general practices (Baker et al 1995). All MAAGs were asked how they classified audits carried out by practices, what information about practice audit was collected and whether any multi-practice audits were taking place locally. On the basis of their findings, the authors concluded that the majority of MAAGs had been "industrious" in carrying out their designated tasks. However, the extent to which MAAG use of a system of classifying audit can be counted as giving direction is open to question. The nature of MAAG "direction" of audit is discussed in more detail in Chapter Eight.

*Studies of specific areas of interest or concern*

The second group (studies 1,3,7,8,10,13 and 14) were concerned with the adequacy of

the MAAG programme in respect of particular areas of interest or concern. These included a study of user involvement in the work of MAAGs in the London region carried out on behalf of the Greater London Association of Community Health Councils, which found extremely limited evidence of user participation either as MAAG members or in the process of audit (Joule 1992). Despite frequent reiteration of the policy expectation that users' views should be taken into account, the more recent national survey of user involvement in MAAGs found little evidence of change in this respect. Only seven of the 86 MAAGs responding to the 1995 survey had any formal user representation. While the majority of MAAGs reported that users had been involved in the audit process in their district, this was most often simply as respondents to satisfaction surveys (Kelson and Redpath 1996).

Another issue that was emphasised in the MAAG circular was the need for strong links with medical education. There were two studies of this aspect of MAAGs, both carried out by academic general practitioners (Spencer 1992; Hobbs 1994). The findings showed that the great majority of MAAGs included members involved in the regional postgraduate network of GP tutors and advisers and/or associated with academic departments of general practice. Nearly two thirds of respondents in the later study were happy with their academic links and nearly one third were not, but the study did not explore the reasons for this variation.

The remaining studies in this group investigated aspects of the programme which emerged as issues of concern as experience accrued and the focus of audit policy shifted over time (see Table 4.3). The first issue was that of monitoring progress. From the outset there was widespread awareness of the need to measure the quality and extent of practice audit so that progress in this area could be assessed. As will be discussed later, a variety of more and less satisfactory approaches were developed locally and two MAAGs (Oxford and Kirklees) published accounts of the methods they had developed (Derry et al 1991; Parker and Barnes 1992). In 1993, a survey undertaken to ascertain what proportion of MAAGs had subsequently adopted the Oxford rating system found that 41% of the 92 MAAGs that responded were using it in original or modified form. However, concern was expressed both by the authors and their respondents about the limitations of such methods of assessing progress (Lawrence et al 1994). The Oxford MAAG has subsequently developed a more sophisticated audit grid which is intended to provide a

**Table 4.3: Developments in primary care audit policy 1989-96**

| *Year* | *Policy document* | *Key points* |
|---|---|---|
| 1989 | *Working for Patients* (Secretaries of State 1989a) | Medical audit introduced as a central feature of NHS policy. |
| 1990 | *Medical Audit in the Family Practitioner Services* (Department of Health 1990b) | Each FHSA to set up a medical audit advisory group (MAAG) to facilitate the development of medical audit in general practice. Audit to be professionally led. No formal expectation of FHSA input into MAAG strategy. MAAGs funded through budget allocation from FHSA. Additional top-sliced monies for specific audit projects to be allocated through regions. |
| 1993 | *Clinical Audit: Meeting and Improving Standards in Health Care* (NHSME 1993b) | Shifted emphasis from uniprofessional medical audit to multi-professional clinical audit. Audit to remain professionally led, but the management contribution to audit strategy to be enhanced. |
| 1994 | *Clinical Audit: 1994-5 and Beyond* (NHSME 1994c) | Recommendation of development of an agreed contract between FHSA and MAAG. |
| 1994 | Letter from NHSME to MAAGs (Field 1994) | Extended provisions of 1990 circular regarding arrangements for MAAGs to 31 March 1996. Emphasised need for MAAGs to encourage multidisciplinary, interpractice and interface audit between primary and secondary care. Encouraged MAAGs to develop business plans.<br><br>End of top-sliced monies for regionally funded audit projects in primary care. |
| 1995 | *The New Health Authorities and the Clinical Audit Initiative: Outline of Planned Monitoring Arrangements* (NHS Executive 1995) | Described clinical audit management responsibilities of new unitary health authorities after 1 April 1996. Recommendation to build on strengths of present arrangements, especially those represented by MAAGs and to ensure that the support and planning of clinical audit in primary care, coordination of interface projects and advice to FHSAs continues. |
| 1996 | *Arrangements for Clinical Audit in Primary Care* (NHS Executive 1996) | Emphasised continuing importance of clinical audit in primary care. Recommended continued existence of a defined audit group. Stressed role of audit in promoting clinical effectiveness and need to further develop a clear patient focus, multi-professional working, an inter-sectoral approach and close links with education and research.<br><br>Merger of FHSAs and DHAs. End of separate arrangements for funding audit in primary care. End of jurisdiction of provisions of 1990 MAAG circular. |

more adequate measure of the appropriateness of audits being carried out and their impact on patient care.

In addition to the question of how to measure progress, uncertainty was expressed in a number of places (and identified in the present study) about the adequacy of MAAG accountability to the FHSA in terms of information provided about activities and progress and FHSA opportunities for input into MAAG strategy. This concern was reinforced by a shift which took place in audit policy in the early 1990s towards expectation of increased management involvement in determining audit strategy. The 1994 survey of FHSA managers and MAAG chairs was commissioned by the NHS Executive to investigate what was going on in this area (Humphrey and Berrow 1995). This study found that MAAGs were collecting a wide range of different types of information but that only a limited proportion of this was made available to the FHSA. The kind of information most wanted by managers was that on the impact of audit and this was provided by less than half the MAAGs in the study. Most managers thought that their MAAGs were taking FHSA interests into account in planning their work but the mechanisms for FHSA input remained quite informal. The same study also looked at what MAAGs were doing in terms of their audit strategy. In this respect too, there had been a significant change in the focus of national policy from medical to clinical audit and increased emphasis on the need for multi-disciplinary audit and initiatives at the interface between primary and secondary care. Findings showed a clear shift in MAAG priorities towards these broader areas and also growing interest in working together with the FHSA on a variety of quality related activities beyond audit.

The final study in this group reflects the most recent developments in clinical audit policy which are linked to the introduction of the new unitary health authorities in April 1996 and involve removal of the division between funding for and organisation of primary care and other clinical audit programmes. The purpose of the study was to explore the extent to which conventional barriers between the quality assurance activities of different health care sectors were already breaking down in anticipation of these changes. Findings showed that by the end of 1995 at least 74% of MAAGs in England and Wales were involved in collaborative quality assurance activities with other agencies or provider groups and were using a wide range of different methods in addition to audit (Berrow et al 1996).

*Studies of the impact of MAAGs*

The third group of studies includes those primarily concerned with the impact of the MAAG programme. Several of the projects discussed above looked at impact as a subsidiary consideration. For example, the study of MAAG accountability investigated manager satisfaction with the work of the MAAGs, the study of collaborative activity included consideration of the success of the initiatives identified and the study by Baker et al (1995) of MAAG activity obtained information on reported levels of participation in audit. This study found an increase in the overall numbers of practices undertaking "any" audit from 57.1% of all practices whose MAAGs collected such information in 1991/92 to 86.5% in 1993/94. However, as the authors observed, the validity of these figures is very questionable because of the known variation in the rigour of the methods used by MAAGs to monitor audit activity. This issue is considered in more detail in Chapter Eight.

In addition, there have been two studies (9 and 12) concerned specifically with the effect of the MAAG programme on quality of care. The first of these was the National Audit Office (NAO) study of the clinical audit initiative in England (National Audit Office 1995). As regards primary care, the study was based on visits to a small number of FHSAs and general practices in three regions and submissions from the NHS Executive including a report which collated the main findings of all the evaluation studies carried out to date and included selected examples of changes following audit identified from MAAG annual reports (Humphrey and Berrow 1994). In the absence of any systematic or validated evidence about the impact of audit, however, the NAO conclusions were confined to the observation that clinical audit appeared, in some cases, to have led to benefits to patients. The study on the impact of MAAG-led audit currently being carried out by Baker and colleagues at the Eli Lilly National Clinical Audit Centre is designed to provide more authoritative information in this area. The study involves a combination of qualitative and quantitative data collection from general practices and MAAG staff in 18 districts. However, no findings from this study are available as yet.

*Qualitative evaluation of Medical Audit Advisory Groups*

The remaining study on the list in Table 4.1 (Humphrey and Berrow 1993) falls within a group of its own because its objectives were different from those of the initiatives so far described. Where the latter sought information about volume and frequency in respect

of a variety of predetermined dimensions of structure, activity and outcome, the investigative focus of the qualitative evaluation of MAAGs was not on measuring "how much?" and "how many?" but rather on finding out "what?", "how?" and "why?". The aims of the study and the reasons for the research approach adopted are discussed below. Details of methods and subjects and practical aspects of carrying out the research are described in Chapter Five.

**Study aims**

The purpose of the study, as already described in the introduction, was to inform future development of policy and practice in relation to MAAGs at both national and local levels by:

i) "mapping" the implementation of the MAAG programme in order to develop knowledge and understanding of how different MAAGs had evolved, what they were doing, why they were working in particular ways and what those involved locally felt about their purpose and activities; and

ii) using the knowledge and insights gained from this exercise to assess and explain progress (or lack of it) towards achieving the objectives of the audit programme.

**Research approach**

The research approach adopted for this study was predominantly qualitative. This approach differs from the more quantitative approach adopted by most of the other studies of MAAGs not only, as mentioned earlier, in the type of questions asked, but also in the methods used and the nature of the information that results. For example, qualitative studies typically:

* use an inductive approach in which data is used to develop generalisations, hypotheses or theory, rather than a deductive approach where data is gathered to test predefined theory or hypotheses;

* adopt an holistic approach which takes account of the influence of the wider local and national demographic, organisational and policy context, rather than focusing on a narrow range of factors directly linked to the subject of the study;

* seek understanding of the phenomenon under study through exploration of its processes and structural characteristics, the subjective perceptions of participants and the interaction between these different aspects, rather than quantification of specific objectively measurable variables or evidence of causal association.

* aim for range, depth and detail in the information collected rather than seeking standardised data on sufficient cases to be adequate for statistical analysis; and

* use open-ended or semi-structured interviews, observation and written documents, rather than pre-coded questionnaires, objective measurement or routinely available statistics.

The importance of qualitative methods is increasingly recognised in health services research and evaluation. For example, in a recent series on the value of qualitative research, Pope and Mays (1995) suggest the use of such methods to explore complex behaviours, attitudes and interactions or topics such as organisational change which are not amenable to quantitative research; to supplement quantitative work, either as part of the validation process or as part of a multi-method approach which examines a particular phenomenon or topic on several different levels; and as a necessary preliminary to quantitative work in circumstances where more detailed understanding of a phenomenon is needed to define what questions are appropriate and how they may be interpreted. Writing more specifically about the use of qualitative methods in evaluation, Patton (1987) suggests that such methods are particularly appropriate for:

* *evaluation of process*, where there is concern to know whether the programme is operating as intended, to identify strengths and problems and to permit policy makers who are not intimately involved to understand what is going on;

* *describing diversity*, where there is a need to understand the reasons for variation between programmes at a local level;

* *evaluating quality,* where there is concern to know about the nature and quality of activities taking place rather than just the extent;

* *responsive evaluation*, where there is a need to know about the priorities and concerns of various stakeholders whose points of view differ;

* *evaluability assessment*, where there is concern to ascertain key variables that may be operationalised quantitatively and/or to ascertain whether a programme is ready for systematic, quantitative evaluation; and

* to add *depth, detail and meaning* to quantitative analyses.

In terms of its objectives and the interests of those who commissioned it, the present study falls clearly within the first of Pope and Mays' categories and incorporates all the purposes identified by Patton. In addition, the adoption of a qualititative approach is appropriate when the study is considered in the context of the wider evaluation programme which includes all the MAAG studies undertaken at different points. As will be discussed later, the use of qualitative methods in this case has enabled validation and further elucidation of the findings of the more quantitative MAAG surveys. Findings from the study have also served as a basis for further quantitative research.

## Chapter Five

# RESEARCH STUDY: METHODS AND RESPONDENTS

This chapter describes the methods adopted for the evaluation of MAAGs. Some practical aspects of the conduct of the research are then discussed and issues of reliability, validity and generalisability are addressed. Characteristics of respondents are also outlined.

## *Subjects and methods*

### *Sample selection*

The logic of sampling in a qualitative study is different from that employed in quantitative research. In a quantitative study, whether the aim is to test an hypothesis or to provide generalisable descriptive information (for example about the prevalence of a particular characteristic in a population), the sample must be large enough to detect statistically significant differences and selected in such a way as to ensure that it is statistically representative of the larger population from which it is drawn. In qualitative studies, numerical generalisations are less important than conceptual generalisations and there are no precise rules governing the number of people or situations studied. This will depend on the aim of the study, as will decisions about subject selection. In some studies it will be important to cover a whole population range, while others may concentrate on identifying examples of particularly important subsets.

The present study required a sample containing a wide range of different MAAGs which would enable elucidation of the ways in which MAAGs varied and identification of any common patterns which cut across this variation. Since there was no systematic information available about the characteristics of individual MAAGs examples of different types could not be chosen directly. It was possible, however, to predict some of the local district variables that might influence what MAAGs did. For example, district characteristics such as geographical and population size would affect local networks and communication strategies. Size and type of general practice were likely to influence the amount of audit already happening in an area and readiness to take it up. The relative complexity of local health service structures would influence the relationship between the MAAG and other agencies and opportunities for audit at the interface. By considering

what health service, general practice and general population characteristics were likely to be relevant to the MAAG and selecting a purposive sample of districts known to vary widely in these respects, it was anticipated that an appropriately heterogenous group of MAAGs might be identified. This approach was therefore adopted.

Two regions (containing 15 FHSA districts between them) were chosen from different areas of the country (one in the south east and one in the north) on the grounds that they seemed likely to contain a reasonable range on all the parameters shown in Table 5.1 and preliminary discussions were undertaken with regional staff to confirm that this was indeed the case.

---

**Table 5.1: Local district variables anticipated to be relevant to MAAG strategy**

---

**Geography/population**

Large/small district
Rural/urban population
Affluent/deprived population

**General practice characteristics**

High/low proportions of singlehanded practices, training practices and GP fundholders
Presence/absence of a local academic department of general practice

**Health service characteristics**

Linked/separate FHSA/DHA
Overlapping/coterminous FHSA/DHA boundaries
One/several local hospitals

---

The rationale for a sample size of 15 (equivalent to a one in six national sample of MAAGs) was that this would be enough, assuming the districts were appropriately selected, to include a wide range of approaches while at the same time remaining manageable within the time available for fieldwork (which was constrained by the NHS Management Executive's request for results as soon as possible). It was anticipated that approximately five interviews would be undertaken in each district, making a total of 75 over a three month period. A potential disadvantage of the sampling approach taken was that any information about the role of regions, should this turn out to be important, would

be based on a sample of only two (out of a potential 14). On the other hand, it would be possible to build up a much fuller view of the part played by these two regions than would have been possible with a more dispersed national sample. Once the two regions were chosen, a summary of the project proposal was presented at meetings of the two regional MAAGs (which were made up of all the local MAAG chairs) and unanimous agreement to take part in the study was obtained. Regional audit coordinators were asked to inform all local FHSA general managers that the region had agreed to participate in the study and to encourage their cooperation.

Within each district, the objective was to find out what the MAAG was doing and how those involved with it perceived its tasks and achievements. It was decided to undertake a limited number of detailed interviews with selected informants in each district rather than a wider survey of the views of GPs whose audit activities the MAAG was designed to support or the service users on whose behalf the programme was being carried out. This decision was based on the assumption that, especially at such an early stage, those who were most actively involved with the MAAG were more likely to be well informed about it and their views would have a greater influence on its work. In the time available, it was not practicable to interview all MAAG members. The decision was therefore made to focus on those individuals with key formal roles in the MAAG and on FHSA staff with professional responsibility for and/or personal involvement in managing the MAAG. By obtaining views of each study MAAG from both professional and managerial perspectives it would be possible to explore the degree of consensus about its role and to identify areas of disagreement.

On this basis, interviews were initially sought in each district with the MAAG chairperson, MAAG support staff, FHSA general manager (as holder of funds and person accountable for the MAAG) and FHSA independent medical adviser (as the only doctor in most FHSAs, this person frequently has links with the MAAG). Names were obtained and responsibilities confirmed by telephoning the FHSA. The decision was taken in principle to limit the number of support staff interviews to one per district. In districts where the MAAG was found to employ both GP facilitators and lay support staff, we chose to focus on the latter, on the basis that lay support staff employed full time by the MAAG were likely to be more central to MAAG activities than GPs who spent at most one session per week working for the MAAG. In places where it turned out that the

medical adviser had no contact with the MAAG, where structural responsibilities varied (such that, for example, the chief executive of a joint health agency was involved with the MAAG instead of or as well as the general manager) or where responsibilities had recently change hands, local advice was followed about whom to approach.

All individual subjects thus identified were sent a letter containing general information about the study and asking them to agree to a confidential interview (see Appendix A). Where jobs were divided between a number of part time staff, we asked to speak to one of the group or several together in the same interview. Letters to MAAG chairs also contained a request for a copy of the MAAG's 1991/92 annual report and any other background documents relating to the MAAG that they would be willing to make available.

*Interviews*

The interviews were based around a schedule of open questions relating to the development and functioning of the MAAG.(see Table 5.2 and Appendix B) The schedule was designed as an interview guide and was developed in consultation with an advisory group consisting of an FHSA general manager, FHSA medical adviser, MAAG member, MAAG lay coordinator, regional audit coordinator and an ex-MAAG chair who was currently responsible in the NHSME for developing primary care audit. The membership of the advisory group was chosen to ensure that, as far as possible, topic areas identified as important by those working with MAAGs in a variety of different capacities would be included in the interview guide. The schedule was piloted in four interviews (with the FHSA general manager, FHSA medical adviser, MAAG chair, and two MAAG facilitators seen together) in a district outside the study regions and modified on the basis of this experience.

The guide was not meant to constrain or limit the issues discussed, nor was it necessary for questions or topics to be taken in any particular order. The aim was to follow the flow of the conversation, with the interviewer free to phrase questions as appropriate and to follow up additional issues that emerged as relevant during the course of the interview. The same interview guide was designed to be used with all participants, to maximise the chances of obtaining systematic and comparable data. However, it was anticipated that the emphasis given to different areas might vary considerably between interviews, since

knowledge of and concern about the various topics and subsidiary items would vary unpredictably between individuals and between categories of respondent. The intention was to ensure that each respondent was given the opportunity to comment on all aspects of the MAAGs' work which were salient to their experience, but not pressed for information which they did not have. When necessary during the interviews, respondents were asked to clarify any differences between their personal views, those of others involved with the MAAG and agreed MAAG strategies.

**Table 5.2: Interview topics and examples of subsidiary items of enquiry**

| Topic | Example of subsidiary item |
|---|---|
| *Setting up of MAAG* | Factors considered in appointment of members |
| *Location of MAAG* | Rationale for location of office |
| *Membership of MAAG* | Roles and responsibilities of different members |
| *MAAG meetings* | Who attends |
| *Finance* | Adequacy and conditions of funding |
| *Relationships with other agencies* | Nature of MAAG / FHSA contact |
| *Local background* | Characteristics and morale of local general practices |
| *Aims of the MAAG* | Extent to which measurable objectives set |
| *Activities of the MAAG* | Methods of supporting audit |
| *Evaluation* | MAAG criteria for assessing quality of audit |
| *MAAG achievements* | Perceived achievements and shortcomings |
| *Future* | Likely life span of the MAAG |

It was anticipated that knowledge about each MAAG's structures and activities would build up cumulatively as the various interviews in each district were completed, so that by the end of each set of interviews a core of systematic data on the functioning of the MAAG would have been obtained. An advantage of this flexible approach was that where several respondents in a district expressed views or provided information about a particular topic these could subsequently be compared to assess the degree of consensus or dissent (in respect of attitudes or opinions) and reliability of factual information (in

respect of issues such as the MAAG budget).

Interviews for each district were completed over a period of one or two weeks, depending on how easy it was to arrange appointments. Interviews lasted for between one and two hours. This variation generally reflected differences in detailed knowledge and the extent of the respondent's concerns about the MAAG but in some cases there were also external constraints on the time available. The interviews were recorded on audio-tape and subsequently transcribed.

Given the difficulty of ensuring reliability between different interviewers in qualitative research, it would have been preferable for all the interviews to be conducted by the author. However, teaching commitments and the travelling distance to interviews meant that this was not possible. The interviews were therefore shared approximately equally between the author (CH) and a research assistant (DB) with an MSc degree in research methods and substantial interviewing experience. It was decided to share out the interviews by whole district, rather than both researchers doing some interviews in each place. Thus all interviews in 7/15 districts (four in one region and three in the other) were undertaken by CH; all interviews in the remaining 8/15 districts (four in each region) were carried out by DB. This method of allocation was chosen because it enabled the researcher to develop more detailed knowledge of a particular MAAG and familiarity with all the key individuals interviewed. This was helpful in identifying identifying areas which needed further exploration and in understanding the links between the different perspectives expressed. The obvious disadvantage was that neither interviewer had direct experience of the other's districts and this compounded the problems of ensuring reliability between interviewers. Moreover, when it came to the analysis, there was a danger of giving undue emphasis to data from the districts where the author had first hand knowledge. These risks were diminished as far as possible by ensuring that all information collected about each district was shared and discussed at every stage and by requesting critical feedback from DB on the categories and conclusions derived from the study.

Other measures to increase reliability included working together to develop the interview guide and sitting in on some of each other's interviews. In the pilot district, the researchers took turns interviewing and observing and this was followed by detailed

discussion of issues arising during the interviews and mechanisms for dealing with them. At the start of the main study, each researcher sat in as observer for all interviews in one district. Throughout the study, the two researchers listened to each other's tapes and discussed each interview as soon as possible after completion so that any issues arising could be borne in mind during further interviews in the same district and the knowledge and experience accrued over the interview period was shared by both interviewers. Despite these precautions, it remains likely that differences between the two researchers in terms of age, personality, experience and background knowledge of audit and primary care did have some effect.

After fieldwork was completed an attempt was made to ascertain whether comparable information had been collected for each district and whether there was any evidence of systematic differences of emphasis. All the core interview topics were found to have been covered at some point for each district but, as was expected because of reasons discussed earlier, the amount of information obtained on each topic and the range of respondents with whom it was discussed varied. There were also a few areas which appeared to have been more consistently covered by one researcher. For example, more information was obtained by CH on respondents' views about how to evaluate the impact of the MAAG. However, one factor that evidently affected the path taken by each interview was whether the MAAG was perceived to be flourishing or failing and whether or not the respondent felt the policy as a whole was worthwhile. It was clear that DB had encountered a larger number of MAAGs with problems and sceptical respondents and for some of these the issue of trying to measure effectiveness appeared to be a relatively minor issue. Given such considerations, it is hard to judge how far variation in the information collected reflected differences of approach by or response to the two interviewers and how far it was due to the evident variation between districts and in the knowledge and interest of respondents and their status vis a vis the MAAG. What can be said with confidence is that the differences of emphasis within each interviewer's group of districts were just as great as those between the two groups.

Our basic knowledge of each MAAG was derived from reading the annual report before the first interview, and we made it clear to all interviewees that we had seen this. As knowledge accrued during interviews, it was sometimes necessary to ask for confirmation or clarification of practical matters, but we were careful not to reveal any attitudes,

opinions or concerns expressed by other respondents. Knowing that some of the issues could be sensitive, we were initially concerned that, despite assurances of confidentiality, respondents might be inhibited from expressing controversial views by their awareness that we were talking to others in the MAAG or FHSA - often on the same afternoon. From the frankness of the responses (which ranged from a general manager expressing major doubts about the future funding for audit which he had not discussed with the MAAG to a lay facilitator criticising what she perceived as the limited ambitions of MAAG members to develop the MAAG's work) it appeared that this was not a significant problem. One reason may have been that individual respondents tended to assume we were sympathetic to their particular point of view, whatever this happened to be. While we took care neither to confirm or deny this, noncommital responses were often perceived as tacit agreement. When such assumptions were made, we usually let them stand for the sake of maintaining good rapport.

A second concern before field work started was that cynicism in some quarters of primary care about the relevance of initiatives coming from the NHS Management Executive might deter respondents from taking the study seriously, since it was known to have been commissioned by them. Again these fears proved groundless. Rather, it appeared that many respondents with strong opinions saw the study as a good opportunity to get their views about their local experience and the MAAG initiative in general taken notice of by those responsible for the policy in the Department of Health.

From comments made in the interviews, four different aspects of the study appear to have been helpful in encouraging participation. First, the involvement of the whole local region (and the exclusion of most others) was seen as increasing local responsibility to make the study worthwhile. Second, the use of interviews - instead of the more usual postal questionnaires - and the fact that the researchers were prepared to travel long distances to undertake them was seen as evidence of commitment to the study which some respondents apparently felt compelled to match. Third, the fact that the study was run from an academic department of public health and primary care in a medical school was regarded by many as assuring impartiality and detachment. Fourth, many respondents were already aware of the author's book *Medical Audit in General Practice: A Practical Guide to the Literature* (Hughes and Humphrey 1990), which had been adopted by the Department of Health and circulated to all MAAGs and FHSAs the previous year. We

(CH, and DB by association) were therefore assumed to be experts on the strengths and weaknesses of audit and to have a realistic understanding of the MAAG initiative. As a result there was more perceived equality between researcher and interviewee than might have been expected given the high professional and managerial status of many of the respondents and this may have encouraged greater candour.

### *Analysis of data*

Analysis of the transcribed interviews was carried out manually. Content analysis involved initially reading the full transcripts several times. Responses relating to a particular theme were then extracted from wherever they occurred in each transcript and broad categories of description were defined and modified using the method of constant comparison until a classification that appeared to satisfactorily describe and "fit" the data emerged. Some themes were determined in advance. These included issues specified in the original MAAG brief (for example strategies for involving all local practitioners in medical audit) and topics relating specifically to the evaluation questions (for example, what mechanisms were being used to assess local audit activity). Other themes emerged as important to understanding the work of the MAAG during the interviews (for example, variations in perception of the appropriate relationship between MAAG and FHSA). The aims of the analysis were partly descriptive - to describe what the MAAGs were doing, how they perceived their tasks and what was wanted from them by the FHSA; partly evaluative - to identify their strengths and weaknesses in relation to local and national needs and expectations; and partly explanatory - to understand why they had developed in this way and suggest what might happen in the future.

### *Validity*

Qualitative research is sometimes criticised as being overly subjective because of the opportunities it offers for the researcher's own views to influence the data obtained and the interpretations put upon it. There is also anxiety because the "arcane and mysterious" process of conceptual analysis is less accessible than that of quantitative analysis to external verification. However, it has been argued that qualitative methods are no more synonymous with subjectivity than quantitative methods are synonymous with objectivity. For example, Patton (1987 p.166) comments:

> *"The ways in which tests and questionnaires are constructed are no less open to the intrusion of evaluator's biases than the making of observations in the field or the asking of questions in interviews. Numbers do not protect against bias; they sometimes merely disguise it. All statistical data are based on someone's definition of what to measure and how to measure it."*

Among philosophers of science, there are now widespread doubts about the possibility of anyone or any method being really "objective". Acknowledging this, Guba and others have suggested that, in relation to evaluation, the really important requirement is research neutrality (Guba 1978; House 1980). Researchers must seek to be impartial, fair and conscientious in taking account of multiple perspectives. They must acknowledge and avoid any conscious predisposition to certain types of findings. It is also important, where possible, to obtain some validation of the findings.

One of the most important methods of validation in qualitative studies is that of *triangulation*. This involves the use of a variety of data sources, investigators or methods in the same study and comparison of the results for convergence. Evidence of convergence gives grounds for greater confidence in the veracity of the findings and the use of multiple approaches is a way of diminishing bias (Denzin 1978). In the present study, there were some opportunities for triangulation of data obtained from different respondents and between interviews and documentary evidence. In some cases such comparisons did identify disagreement on factual issues (such as the size of the MAAG budget or who was a member of the MAAG). Mostly there were grounds for assessing which source was more likely to be correct (for example MAAG staff could be assumed to be better informed about day to day aspects of MAAG functioning than FHSA managers who were only indirectly involved) but the evident inaccuracy of some of the responses was itself an important finding. There was also some built in "investigator triangulation" through the involvement of a second researcher in data collection and as a sounding board during the analysis to help identify and diminish the effect of any idiosyncratic biases on the part of the author. Finally, there was some limited triangulation of methods through the use of documentary sources as well as interview data. However, because the documents used (mainly annual reports, mission statements and some minutes of MAAG meetings) had usually been written by the respondents being interviewed, they cannot be regarded as an independent or objective source of information. In particular, several respondents acknowledged that the content of their annual report was influenced by the need to present the MAAG in a good light. A much

more powerful form of methodological triangulation would have been to include some direct observation of MAAG activities to compare with respondents' claims about what they were doing. Unfortunately, this was not possible within the time available. The findings are therefore based entirely on what the respondents said. As will become clear, many respondents were quite self-critical about the approach taken, for example, in the MAAG's work with practices and it could be argued that this willingness to acknowledge limitations provides some reassurance that they were telling the truth as they saw it. However, the possibility remains of a significant gap between perceptions and behaviour and the absence of any means to assess this gap is an important, if unavoidable, limitation of the study design.

A further means of assessing accuracy is that of *respondent validation*. This involves checking the subjective validity of the meanings and explanations derived from the data through feeding the findings back to the study subjects and seeking their assessment of the correctness of the interpretation. In the present study this was done by holding half-day workshops in the two regions approximately three months after the field work was completed at which the preliminary findings were presented and discussed. All those who had participated in the study were invited, along with representatives of the Department of Health. In all, 57 people attended the two workshops. There was general consensus that our interpretation of the findings rang true and none of our conclusions were disputed, but a few respondents mentioned ways in which their MAAG's strategy or circumstances had already altered since the interviews.

### *Generalisability*

As already noted, the study districts were not selected in such a way as to be statistically representative of the national population. However, comparisons against national data on demographic and health service characteristics of FHSA districts and with the findings of other studies of MAAGs enable some assessment to be made of how typical or exceptional the sample was in relation to the larger group. In the chapters which follow, such comparisons are made wherever possible and show close congruence between the study sample and national figures on almost every parameter measured.

Further evidence in this regard is available from the findings of the 1994 national survey

of MAAG accountability (Humphrey and Berrow 1995) which was discussed in Chapter Four. This study obtained information by postal questionnaire from 90 (92%) of MAAGs and 85 (89%) of FHSAs in England and Wales including responses from 14 of the 15 districts in the present study. Questions were asked about a number of different areas including MAAG priorities for audit; MAAG collaboration with the FHSA on wider quality issues; information collected by the MAAG and communicated to the FHSA; and FHSA satisfaction with the MAAG in various respects.[4] Separation of the findings for the 14 study districts and comparison against the rest of the sample using a Chi-square test showed no statistically significant differences on any of the 37 variables for which information was available (See Appendix C). These results indicate that eighteen months after the completion of the present study the study MAAGs were collectively indistinguishable from those in the rest of the country, at least on those measures.

*Characteristics of respondents*

Everyone approached for an interview agreed to participate. A total of 68 people were interviewed between November 1992 and February 1993. However, at interview three of the respondents were found to have been chosen inappropriately. They included one general manager (District 5) who was so new in post that he had not yet come across the MAAG (the outgoing general manager was also interviewed), one medical adviser (District 8) who had no contact with the MAAG and professed to have no knowledge or opinion about it either, and one FHSA clerical assistant (District 6) whose only involvement with the MAAG was the fact that she typed the minutes of its meetings. These interviews were subsequently excluded from the analysis as they contained little information of any relevance. The occupational distribution of the remaining 65 respondents is shown in Table 5.3.

As may be seen, the number of people interviewed and the designation of these respondents varies quite a lot between districts. This reflects major local differences in MAAG organisation and in allocation of responsibilities within the FHSA. The only potential respondent group which is significantly under-represented in the sample is that

[4] A detailed account of the methods used in this study is provided in the paper appended at the back of this thesis (Humphrey and Berrow 1995).

of MAAG GP facilitators. As explained earlier, this reflects the decision to approach lay support staff in preference where these existed. A second reason for the comparative neglect of GP facilitators is that they were very rarely mentioned as relevant when we telephoned the FHSAs to ask advice about which individuals to interview. Consequently it was only once the interviews were underway that the large numbers of (very part time) facilitators employed in some districts became apparent.

**Table 5.3: Occupational distribution of 65 subjects interviewed and eligible for inclusion in the study in 15 MAAGs in England**

| | FHSA | | | | MAAG | | |
|---|---|---|---|---|---|---|---|
| MAAG | General Manager | Chief Executive | Medical Adviser | Other Directorate | Chair | Lay Support Staff | GP Facili-tator |
| 1 | + | o | + | - | + | + | o |
| 2 | + | o | +1/3 | - | + | + | !17 |
| 3 | o | + | +2 | - | + | + | o |
| 4 | o | + | + | - | + | o | +1/7 |
| 5 | + | o | + | - | + | o | +1/2 |
| 6 | + | o | - | - | + | + | o |
| 7 | + | o | + | - | + | + | !6 |
| 8 | + | o | - | - | + | + | !8 |
| 9 | + | + | - | + | + | + | o |
| 10 | + | o | + | - | + | o | + |
| 11 | + | o | o | + | + | +4/4 | o |
| 12 | + | + | + | - | + | +2/2 | o |
| 13 | + | o | + | - | + | + | o |
| 14 | + | o | +2/2 | - | + | o | +1/4 |
| 15 | + | o | - | - | + | + | !5 |
| Total | 13 | 4 | 12 | 2 | 15 | 15 | 4 |

Key:

| | |
|---|---|
| + | Postholder interviewed |
| +2 | Two people interviewed (old and new incumbents) |
| o | Nonexistent position or nobody in post |
| +2/2 | Number interviewed (jointly) / total number of part time postholders |
| - | Person in post but not involved with MAAG |
| ! | Employed by MAAG but not approached for interview |

One of the FHSA general managers and nine of the medical advisers (or members of other FHSA directorates) interviewed were found to be also MAAG members. The titles, grades and responsibilities of lay support staff varied considerably between MAAGs. In the chapters which follow, they are referred to generically as "MAAG support staff". Similarly, the term "general manager" is used to include both FHSA general managers

and chief executives of commissioning agencies. The term "medical adviser" is used to include two directors of primary care or quality assurance who performed a function similar to that of the medical adviser.

*Presentation of findings*

In the chapters which follow, the study MAAGs and their associated districts are numbered (1-15 in the order that the interviews took place) and members of the various respondent categories are identified by letter (MAAG chair = C, MAAG support staff = S, GP facilitator = F, FHSA general manager = G, FHSA medical adviser = M). These designations are used, where appropriate, to indicate which MAAGs or members of a particular respondent category are being referred to. In discussing issues on which the views of different categories of respondents varied significantly, the differences are made clear. Where a reasonable consensus was found, no distinctions are made. Respondents in all categories frequently referred to the MAAG as an entity possessed of its own attitudes and perceptions. Where it seems appropriate, this usage is adopted.

Some basic frequency data for the sample as a whole are presented in tables. These relate, in the main, to the core structural features and activities of the study MAAGs about which information was collected systematically. Beyond the basic topics which were covered with every respondent and for every MAAG, the detail of the information collected varied according to the particular interests and concerns in each locality. In these areas precise ennumeration is not possible because neither numerator nor denominator can be given with certainty and therefore no attempt has been made to quantify the number of respondents holding a particular view or MAAGs adopting a particular strategy beyond indicating whether these appear to be exceptional or are widely shared.

Given the mass of material obtained from the interviews (approximately 500 pages of typewritten transcripts), some selection was inevitable. In choosing what to present in the results the emphasis has been, first, on describing the structural attributes, attitudes and activities which appeared from the circular or emerged from the interviews as central to understanding the character and outlook of the study MAAGs and, second, on identifying factors - from individual personality characteristics to issues of national politics - which

help explain their common features and the differences between them. Quotations from interviews are used selectively, not just to "bring the text to life" although they do help to do this, but also because, on many occasions, the tone and style of people's comments as well as what they said give important clues about their attitudes and perceptions and thereby help explain what was going on.

## Chapter Six

# STUDY DISTRICTS AND STRUCTURAL FEATURES OF THE MAAGS

This chapter begins with a brief description of the study districts. It goes on to look at how the study MAAGs were set up, the nature of their membership and the additional staff they appointed, and the resources available to them in terms of funding and other facilities. For each of these areas, findings for the study MAAGs are compared to Department of Health expectations as stated in the MAAG circular (Department of Health 1990b) and to data from other contemporary studies where these are available. A number of differences are identified between the initial make-up and circumstances of the various study MAAGs which help explain the contrasting perspectives and strategies they subsequently adopted.

### *Characteristics of the study districts*

Table 6.1 presents data for the 15 study districts in respect of geography and population, general practice and health service characteristics. National data are also given where available to enable some assessment of how "typical" the study districts are as a subgroup of the whole. As may be seen, the mean values for the study sample are similar to the national figures in most respects, although the study districts contained slightly higher proportions of training and fundholding practices.

As mentioned earlier, the two regions chosen for study were selected on the basis that the districts within them varied significantly in a number of ways that might influence MAAG strategy. Table 6.1 shows the extent of that variation and confirms that heterogeneity has been achieved on all the measurable variables anticipated to be relevant (although the range in size of study district is slightly narrower than exists nationally).

During the course of the interviews it became clear that there were a number of other differences between the study districts that cannot be adduced from the figures presented above but were just as significant in terms of their impact on the MAAGs. Among the most notable of these was the varying *stability* of service organisation, the differing degree of *coherence* in terms of shared needs and shared identity within a district,

**Table 6.1: Selected characteristics of study districts and national comparisons**

| District | Type of district | Popn. x1000 | Area square miles | Under privil eged area score* | GPs No. | GMPs No. | Single-handed % | Fund-holding practices % | GP trainers % |
|---|---|---|---|---|---|---|---|---|---|
| 1 | London borough (inner + outer) | 592 | 36 | 3.37 | 263 | 128 | 49 | 13 | 12 |
| 2 | County | 969 | 1015 | -10.73 | 481 | 164 | 29 | 37 | 24 |
| 3 | Metropolitan district | 294 | 225 | 1.34 | 149 | 49 | 27 | 8 | 16 |
| 4 | County | 566 | 477 | -10.50 | 275 | 90 | 30 | 14 | 13 |
| 5 | Metropolitan district | 240 | 110 | - 0.03 | 111 | 39 | 36 | 15 | 10 |
| 6 | London borough (outer) | 254 | 42 | - 3.23 | 120 | 54 | 44 | 7 | 13 |
| 7 | County/city | 578 | 2289 | -15.34 | 20 | 108 | 23 | 18 | 21 |
| 8 | Metropolitan district | 526 | 140 | 12.90 | 311 | 116 | 29 | 12 | 23 |
| 9 | London borough (outer) | 372 | 35 | - 4.93 | 179 | 78 | 37 | 1 | 19 |
| 10 | Metropolitan district | 228 | 126 | 0.49 | 112 | 40 | 28 | 10 | 15 |
| 11 | London borough (inner + outer) | 811 | 50 | 16.80 | 374 | 186 | 45 | 4 | 6 |
| 12 | County/city | 906 | 984 | - 9.73 | 472 | 147 | 27 | 19 | 17 |
| 13 | London borough (inner) | 414 | 13 | 27.59 | 192 | 103 | 50 | 8 | 9 |
| 14 | County | 1035 | 634 | -21.90 | 557 | 148 | 24 | 16 | 24 |
| 15 | County/city | 1014 | 833 | - 4.55 | 494 | 183 | 28 | 9 | 17 |
| Study mean | | 587 | 467 | - 1.23 | 395 | 109 | 34 | 13 | 16 |
| Study lowest | | 228 | 13 | -21.90 | 111 | 39 | 23 | 1 | 6 |
| Study highest | | 1035 | 2289 | 27.39 | 557 | 186 | 50 | 37 | 24 |
| Ratio of least:most in study | | 1:4.5 | 1:176 | | 1:5 | 1:4.8 | 1:2 | 1:9 | 1:4 |
| National mean | | 559 | | 0.00 | 292 | 104 | 33** | 7*** | 12** |
| National lowest | | 130 | | -27.22 | 71 | 20 | | | |
| National highest | | 1600 | | 57.47 | 850 | 370 | | | |

**Table 6.1: Selected characteristics of study districts (continued)**

| District | FHSA coterminous with one or more DHAs | Number of DHAs to which FHSA relates | FHSA/DHA already merging | Medical school |
|---|---|---|---|---|
| 1 | no | 2 | no | no |
| 2 | yes | 2 | no | no |
| 3 | yes | 1 | yes | no |
| 4 | yes | 2 | yes | no |
| 5 | yes | 1 | no | no |
| 6 | yes | 1 | no | no |
| 7 | yes | 2 | no | no |
| 8 | yes | 1 | no | yes |
| 9 | yes | 1 | no | no |
| 10 | yes | 1 | no | no |
| 11 | no | 3 | no | no |
| 12 | yes | 1 | no | yes |
| 13 | no | 1 | no | yes |
| 14 | yes | 4 | no | no |
| 15 | yes | 3 | no | yes |

Key: GMP = general medical practice
Fund-holding includes first and second wave fundholders only

Sources:
* (Department of Health 1995)
** (Fry 1993)
*** (Audit Commission 1995)

contrasting levels of general practice and FHSA *morale* and the presence or absence of strong *leadership* somewhere in the picture.

*Stability*

In the early 1990s, as mentioned earlier, all districts experienced important changes in the organisation of primary care with the transformation of family practitioner committees into FHSAs with their wider responsibilities and new tasks. By 1992, further modifications were already on the agenda with the proposed "merger" of FHSAs and DHAs and the creation of joint health commissions. Such coming together had already occurred in two of the study districts and several more were moving in that direction. In other places, however, merger had not yet become an issue.

Associated with these structural changes, some districts had experienced considerable upheaval among managerial staff. The FHSA in District 13, for example, had had five different general managers in a period of just six years. Elsewhere continuity had been maintained and the general manager who oversaw the introduction of the MAAG had considerable knowledge of the district and a longstanding relationship with local GPs which went back well before the creation of the FHSA. Not all these relationships were entirely positive, though in some places a good deal of trust had been built up on both sides. But, even where relations were strained, the reciprocal familiarity between GPs and management meant that both were reasonably confident about what to expect from each other in relation to a new challenge like the MAAG.

In districts where there was no such mutual history, attitudes were much more unpredictable and the consequence was greater wariness on both sides. Particularly where new managers had come from other sectors of the NHS (as was the case in both the districts with new health commissions), there was concern among GPs that they would not understand or care about primary care or know how to deal with GPs appropriately. For their part, these managers were well aware of their lack of relevant experience and most sought to cope with this by holding back, at least until such a time as they had "earned their spurs" with local GPs. Compared with the old hands, the recently arrived managers tended to be much less active participants in matters concerning the MAAG.

*Coherence*

By definition, every FHSA district acts as a single administrative unit, but not every district is a meaningful entity in other ways. In places where district boundaries correspond with other administrative, social and geographical divisions, the chances of a shared local identity are much greater. The same is likely to be true of districts which contain one, rather than several, main towns and a homogenous population rather than several distinct groups with different environments and diverse needs.

While some of the study districts shared name and location with cities going back a thousand years, others were creations of NHS bureaucracy with little historic or contemporary social meaning. In some places all practices were linked by a common district hospital. Elsewhere GPs with contrasting practice profiles looked out beyond the district in opposite directions. In places where there was a good fit between existing communication networks and FHSA boundaries and where GPs identified themselves as belonging to a common district, establishing the MAAG was an easier job simply because in local terms it made more sense. In contrast, for MAAGs such as that in District 1 where the only real connection between the two components of inner city and prosperous suburbs was the motorway which separated them, the difficulty of developing a strategy which could link the two areas and address the disparate needs of the practices within them remained a constant preoccupation.

*Morale*

The expectation that doctors should do audit was part of a much wider set of new demands on general practice associated with the introduction of the 1990 contract, the advent of fundholding and the need to grapple with computerisation. All GPs were faced with responding to these changes, but they approached them from very different starting points. Those that were functioning well before the new contract were able to take the challenges in their stride and adapt to the new environment of targets and health promotion clinics quite successfully. Those that were already disorganised, short on staff and under stress were much less well-equipped.

Among the study districts, the depth of the shadow cast by the new contract and reported levels of morale among GPs were very variable. In general, those districts with younger doctors and better off, more stable local populations were feeling better than those with

the opposite attributes. However, this was not consistently the case. Some places had their own peculiar local climates which confounded expectations. In District 9, for example, all the respondents interviewed concurred in describing the local GPs as exceptionally negative and apathetic but none could give an explanation as to why this was. Wherever practices were, for whatever reason, already feeling demoralised and put upon, getting them to respond to or help develop a new initiative like the MAAG was inevitably harder.

A further factor influencing GP attitudes was the nature of the local political environment. While every district had a local medical committee (LMC), the influence and orientation of these committees varied considerably. Some concentrated mainly on the local domestic agenda in relation to the FHSA and in most such places FHSA and LMC were rubbing along together more or less comfortably on the basis of "mutual disrespect". Other LMCs, in contrast, contained GPs who were active participants at a national level in a much more militant battle against the NHS reforms. In these places official relations with the FHSA were influenced by ideological propriety and were often rather cool. While such LMC members often had nothing against audit as a tool for improving practice, antipathy on principle towards any policy coming from the Department of Health meant that the MAAG initiative was greeted with mistrust.

*Leadership*

The nature of the MAAG initiative - the lack of comparable precedents, the limited guidance in the circular as to how MAAGs should work, the ambiguity of their role vis a vis the FHSA and the fact that they required voluntary commitment over and above their normal work from the doctors who became involved with them - meant that determined individuals with strong views about audit would have ample opportunities to influence what happened locally. By the same token it could be argued that the initiative had particular need of someone with vision and leadership to make it work.

In several of the study districts there were people who, for a variety of reasons, were eager to take on this role. For example, in District 12 there was a professor of general practice who had written an MD thesis advocating the benefits of medical audit almost 20 years earlier and saw the MAAG as a golden opportunity to promote a cause he passionately believed in. Elsewhere there were several managers who saw the possibility

of using a professional audit group for purposes of their own. One or two were keen on the MAAG - as they would have been on any new initiative - because they wanted to be in the vanguard of progressive managers and to ensure that their FHSA was seen as a success. In other places there were no great enthusiasts of any sort either among management or the profession. In a few districts, as indicated earlier, the interest shown by LMC members was actively negative, their main concern being to prevent the MAAG from imposing inappropriately on local practices.

In the chapters which follow, the significance of the district characteristics just described in determining local reaction to the MAAG circular and influencing what the study MAAGs went on to do will be considered in more detail. The first point at which local factors made an obvious difference was in the process of establishing the MAAG. This is discussed below.

*Setting up the MAAG*

The MAAG circular published in the spring of 1990 (Department of Health 1990b) contained detailed recomendations on the categories of membership for MAAGs and the process whereby members should be appointed. (A copy of the circular is included as Appendix D.) Each MAAG was expected to contain not more than 12 members who were medically qualified, most of these being local GP principals. It should include doctors with recognised expertise in medical audit, some with educational connections such as Regional or Associate Advisers in General Practice or academic GPs from a local medical school, a clinical or service department consultant associated with medical audit activities in the local hospital services and a public health physician. Other members of the primary health care team might be included through co-option.

Beyond these stipulations, the precise size and composition of the group was regarded as a matter for local agreement. Each FHSA was required to invite nominations for GP membership of the MAAG from the local medical committee and the local Faculty of the Royal College of General Practitioners (RCGP). The FHSA could also propose members itself. The FHSA was expected to agree its choice of members with the LMC "to ensure that the MAAG commands the confidence of both the [FHSA] and the profession locally." MAAGs were to be in place by April 1991.

In the months leading up to April 1991, there were major differences between the study districts with regard to who was involved in setting up the MAAG. While some FHSA managers took a close personal interest in choosing the members, others played only a nominal role, either delegating the task to a selected subgroup or ceding control entirely to the LMC. The path followed in each district depended on the attitudes towards audit and towards each other of all the various players potentially involved. In seven of the 15 districts, the issue of setting up was treated as an overt battle for control of the MAAG between the LMC and the FHSA. In the remaining eight, ownership appeared to be much less of an issue, either because there was little disagreement about who should be on the MAAG or few strong feelings either way. These contrasting *oppositional* and *consensual* approaches are described below.

*Oppositional approaches*

In five of the 15 districts (3,6,9,10,14) the LMC took the initiative early on by setting up its own shadow audit group which was then presented as a *fait accompli* to the FHSA and transformed into a formal MAAG at the appropriate date simply by adding the requisite non-GP clinicians. The motives of the LMCs that took such pre-emptive steps appear to have had less to do with enthusiasm for audit than with determination to ensure independence from the FHSA and specifically to ensure that neither FHSA managers nor medical advisers became members of the MAAG. (Although FHSA representation was not mentioned in the circular, it was widely - and correctly - anticipated that most FHSA managers would seek some presence on the MAAG.) In the event, only one of the LMC-led MAAGs (MAAG 3) ended up with any FHSA presence among its members and in this case the medical adviser was invited to join on personal grounds because of his high standing among local GPs and his exceptional experience of audit. When he retired, the new medical adviser was not invited to become part of the group. For this group of MAAGs generally, medical advisers, despite being doctors, were regarded as irrevocably compromised by their managerial links and any suggestion that they should be included in the MAAG would have been met by threats of mass resignation.

In the five districts just described, the FHSA managers accepted the lead taken by the LMC, either because they were not particularly interested in taking charge themselves or to avoid antagonising local GPs. Elsewhere, however, two general managers with strong ambitions of their own for the MAAG used more active strategies to deal with

LMCs whom they perceived as potentially obstructive. In District 2 the general manager deliberately prevented the LMC from setting up a shadow audit group because he was concerned that the LMC was not representative of "ground floor" GPs. This manager claimed to have "stitched up the MAAG" and adroitly side-stepped local politics by going outside the district to appoint a respected academic GP as chair. He also wrote the ground rules of the MAAG and "stacked" the membership with three part-time FHSA medical advisers to diminish the influence of the LMC. In District 7 the manager took the precaution of writing the MAAG constitution himself, personally appointing the GP facilitators who would work for it and ensuring the participation of the medical adviser before appointing the remaining members. He then sought to disarm potential opposition by co-option, appointing the chairman of the LMC, who was well known for his cynical views about audit, as chair of the MAAG.

*Collaborative approaches*

In the eight remaining districts (1,4,5,8,11,12,13,15) neither the LMC nor the general manager chose to take such a dominant role and in these places the creation of the MAAG was much more of a joint enterprise undertaken by a mixed FHSA/professional sub-group made up of those with a formal interest in the MAAG (as LMC or RCGP representatives or FHSA medical advisers) or a personal enthusiasm for audit. In these places general managers mostly limited their own involvement to negotiating the appointment of one or two key GPs as members, to ensure there was someone in the MAAG to whom they could relate. Most managers also encouraged the involvement of the FHSA medical adviser as a member of the MAAG - seeing this as the best means of ensuring that FHSA interests were represented while maintaining the principle of a professional MAAG - and this was accepted by the others in the sub-groups. The one exception was District 15 where the manager deliberately chose to become a MAAG member himself in order to ensure appropriate separation between MAAG and FHSA responsibilities for audit:

> *"The FHSA has accepted entirely that medical audit is about continuing medical education. As I am on the MAAG I can maintain the distinction between mangerial and medical audit, and if I think the MAAG is looking at something that I think is in the FHSA remit, or vice versa, then I will say so. The [medical adviser] is not a member of the MAAG as he is more concerned with managerial audit."(G15)*

Two other general managers attended early MAAG meetings as observers (and

subsequently withdrew), but none of the rest were directly involved as members.

The significance of this variation in how the MAAGs were created is that it resulted in major differences between districts as to whose views were represented in the selection of MAAG members. It also had a continuing influence on the relationship between MAAG and FHSA in terms of attitudes and expectations as well as formal contact. In districts where there was already some antagonism between LMC and FHSA, the MAAG ended up with either no management input or quite a large amount, depending who took charge. In more neutral districts where management control was less of an issue all the FHSAs had some involvement with their MAAGs but none had very much.

### *Choosing members*

A variety of different recruitment strategies were used by those involved in setting up the MAAGs in order to produce the required membership. In a few districts, the prescribed nomination process was simply followed through with little apparent thought about the nature or purpose of the group that would result:

> *"It was very much to the letter of the circular. They just recruited all these people, who then got together and decided how they were going to do audit."(S11)*

In most places, however, those involved had some idea of the kind of MAAG they wanted and took active steps to achieve this, either by identifying desirable individuals and actively manipulating the nomination process to ensure they got chosen, or by accepting a core of nominations and then remedying perceived gaps by co-option. Apart from the strategic concerns about FHSA and LMC involvement with the MAAG discussed earlier, the two main considerations that appear to have informed local decisions about membership were the *representativeness* of the MAAG and the need to equip it with the appropriate individuals and skills to do its job *effectively*.

#### *Representation*

It was generally recognised that the nomination process for GP MAAG members specified in the circular would tend to produce "the same old faces" that turned up everywhere. In some places this was regarded as both inevitable and appropriate:

> *"I don't think you could have it representative. In this district only a small number*

*of the GPs are awake, many are buried in the woodwork. The people on the MAAG will tend to be the lively articulate ones who are already on committees."(C6)*

Elsewhere, the fact that the main ideological strands in general practice were assured of representation was seen as sufficient in itself:

*"The LMC contains the pragmatists and the RCGP contains the idealists. And we have non-general practitioners to give an outside perspective. So I think the eventual group is reasonably representative."(C4)*

But not everyone regarded this as adequate and most sub-committees attempted to ensure that the MAAG had a reasonably good geographical spread of members and that significant constituencies with special needs or concerns (particularly single-handed GPs) were represented. Most also thought about representation in terms of gender and ethnic mix and - often belatedly - tried to do something about this by appointing token individuals:

*"When we had the first meeting we discovered we had no single-handed doctor and no doctor from the ethnic minorities. We actually had no women either. We addressed the single-handed and ethnic minorities by co-opting Dr B. who is both."(M4)*

However, none of the sub-groups set out to achieve a MAAG that was statistically representative of the local GP population in these respects and none came near to achieving this.

*Effectiveness*

A central concern in most districts was to construct a MAAG that would be able to work with local general practice, and this was widely anticipated to be quite a difficult task. There was an expectation of negative attitudes towards medical audit among GPs on the ground due to mistrust of its purposes, inexperience of its benefits and perceived linkage with other unpopular health reforms, particularly the new GP contract. Even those GPs who were more favourably disposed towards audit were expected to have problems in finding the time and resources to undertake it.

The perceived need to reassure local practitioners of the MAAG's good intentions, and specifically to emphasise the separation of its role from managerial monitoring, was addressed in a variety of different ways. In some places, priority was placed on appointing individuals well known locally for their steadiness, political integrity and trustworthiness, especially to the key post of MAAG chair:

*"I wouldn't say he is a driving force, but he certainly has the confidence of all the practices because he is the chair of the LMC. He's the safe pair of hands."(S7)*

In districts where there were established senior figures associated with the RCGP, the MAAG's commitment to educational values and professional quality was signalled by the appointment of such individuals to the MAAG. Where there was a local medical school, efforts were made to emphasise links with the independence and objectivity of academic general practice. Six districts (2,3,7,8,12,15) recruited established academic GPs to their MAAGs and in three of these (2,12,15) professors became MAAG chairs. However, such active choices were not possible everywhere. In District 9 hardly anyone was interested in becoming actively involved and the person who became MAAG chair did so not on grounds of her skills, experience or reputation but simply because "nobody else was willing".

In contrast to the considerable thought given in almost all the study districts to constructing a MAAG that would be acceptable to local practices, the priority accorded to other skills and attributes was much more variable. Some sub-groups (particularly those involving FHSA managers) were concerned about the need for good communication:

*"[The chair] had to be someone who gets on with the general manager - that they mutually respect each other. It had to be someone known to the authority, and it had to be someone who could communicate with his or her colleagues. And someone who's not macho in style, because that style of person only delivers a limited range of people."(G1)*

Others were more preoccupied with appropriate status. For example, in District 12 an ambitious general manager and a professor of general practice who was a longstanding audit enthusiast set out to recruit as many high status individuals as they could, on the principle that an elite MAAG with powerful connections would be in the best position to help set the agenda nationally, maintain high standards and obtain whatever resources might be available at a regional or national level.

At the other extreme, the LMC-led group in District 10 took the opposite view and tried to create a MAAG with which ordinary GPs would be able to identify:

*"We wanted to make sure that there were enough of what could be considered to be normal GPs. Basically by "normal", I mean an unaligned GP, one who is not politically active. Probably not a trainer or other committee member."(C10)*

Besides their greater "street credibility", such GPs were seen as more likely to have time and energy to commit to the MAAG than those who already had numerous additional responsibilities.

Other sub-groups were less concerned about status and image of any particular kind and simply looked for activists with the energy and enthusiasm to get things going at the grass roots. Surprisingly, given the purpose of the MAAG, most sub-groups appear to have given relatively little priority to the need for specific audit skills and experience among its members.

*Membership of the study MAAGs*

The results of these different approaches to constructing the MAAG were paradoxical. At a formal level all led in the end to a relatively standard product. Table 6.2 shows the members of the study MAAGs in terms of professional categories. As can be seen, all of them had broadly conformed to the recommendations in the circular. All were numerically dominated by GPs and all but one included one or more other clinicians. All contained one or more GPs with some connection with continuing medical education or other academic links and all had representation from the LMC and RCGP.

The main departure from the circular, as already indicated, was the large proportion of MAAGs that included FHSA medical advisers among their members. At the time of the study, only one MAAG (MAAG 2) had taken up the option of extending the professional membership beyond doctors by co-option of a nurse. One other (MAAG 15) had gone a step further by appointing the secretary of the local community health council as a member and, as already mentioned, by including its general manager. As the table shows, these findings are very similar to those of the 1992/3 survey of 85 MAAGs carried out by the Birmingham MAAG (Houghton and Sproston 1995).

Beyond the formal level, though, the differing visions that influenced their construction and the varying skills, attitudes and motivation of those recruited resulted in a group of 15 MAAGs which differed profoundly from one another in character and outlook, in what they set out to do, in the strategies they adopted and in the extent of their commitment

**Table 6.2: Membership of study MAAGs and national comparison**

| Study MAAG | General practice | Public health doctor | Hospital doctor | FHSA medical adviser | FHSA general manager | PHCT rep. | Lay person | Total membership |
|---|---|---|---|---|---|---|---|---|
| 1 | 7 | 1 | 2 | 1 | - | - | - | 11 |
| 2 | 8 | 2 | 2 | 3 | - | 1 | - | 16 |
| 3 | 9 | 1 | 1 | 1 | - | - | - | 12 |
| 4 | 9 | 1 | 2 | 1 | - | - | - | 13 |
| 5 | 8 | 1 | 1 | 1 | (1)* | - | - | 11 |
| 6 | 10 | 1 | 1 | - | - | - | - | 12 |
| 7 | 8 | 1 | 1 | 1 | - | - | - | 11 |
| 8 | 11 | 1 | 1 | - | (1)* | - | - | 13 |
| 9 | 7 | 1 | 1 | - | - | - | - | 9 |
| 10 | 8 | 1 | 1 | - | - | - | - | 10 |
| 11 | 9 | 1 | 2 | 1 | - | - | - | 13 |
| 12 | 7 | 1 | 1 | 1 | - | - | - | 10 |
| 13 | 11 | - | - | 1 | - | - | - | 12 |
| 14 | 5 | - | 1 | - | - | - | - | 6 |
| 15 | 7 | 1 | 2 | - | 1 | - | 1 | 12 |
| Study least | 5 | | | | | | | 6 |
| Study most | 11 | | | | | | | 16 |
| Percentage of MAAGs in study including such a representative | | 87% | 93% | 73% include FHSA staff as members or observers | | 7% | 7% | |
| National least | 5 | | | | | | | 6 |
| National most | 13 | | | | | | | 16 |
| Percentage of MAAGs in national survey of 85 MAAGs including such a representative (Houghton and Sproston 1995) | | 85% | 84% | 76% include FHSA staff as members or observers | | 19% | 4% | |

KEY: * Managers in brackets attended MAAG meetings as observers

to making the MAAG a success. The nature and effects of these differences will be explored further in the chapters which follow.

### *MAAG Staff*

Beyond specifying the membership, the circular said little about how the MAAG should be staffed. The one explicit suggestion was that MAAGs should appoint a team or teams who would be responsible to the group for assisting practices with the development of audit. Each team was expected to consist of two to four general practitioners knowledgeable in medical audit and at least one member of each team should be a member of the MAAG. MAAGs were also expected to be provided by the FHSA with adequate clerical and secretarial time to enable the MAAG and its audit team(s) to carry out their responsibilities.

By the time of interview, all the study MAAGs had appointed part-time GP facilitators and/or full-time lay support staff (see Table 6.3). In addition, nine of the 15 had their own secretarial support. These findings are similar to those from Griew and Mortlock's (1993) study of a national sample of 15 MAAGs carried out in 1992, which found that 13/15 MAAGs employed such staff. In the 1992/93 national survey carried out by Birmingham MAAG, 95% of the 85 MAAGs responding had dedicated support staff (Houghton and Sproston 1995).

#### *GP facilitators*

Decisions about employing GP facilitators depended on what MAAG members expected to do themselves. Some groups (4,5,12,14) agreed early on that the MAAG itself should act primarily as a committee:

> *"We decided as a MAAG that we would be a policy-deciding body - a management body - rather than the ones who would go out and do the work."(C12)*

Others (1,3,6,9,13) took the opposite view, seeing it as essential that all MAAG members were personally committed to working with practices. The remainder left decisions about participation up to individual members. Where GP facilitators were employed, it appeared that some effort had gone into seeking out people with relevant practical or interpersonal

**Table 6.3: Study MAAG employees and location of MAAG office**

| MAAG | GP facilitators | Lay support staff | Secretarial assistance | Office in FHSA | Office elsewhere |
|---|---|---|---|---|---|
| 1 | - | 1 | 0.5 | - | in hospital |
| 2 | 17 p/time | 1 | 0.5 | yes | - |
| 3 | - | 1 | 1.5 | yes | - |
| 4 | 7 p/time | - | 0.5 | yes | - |
| 5 | 2 p/time | - | 1.0 | yes | - |
| 6 | - | 1 | 1.5 | - | in hospital |
| 7 | 6 p/time | 1 | 0.5 | yes | - |
| 8 | 8 p/time | 1 | - | yes | - |
| 9 | - | 1 | - | - | in hospital |
| 10 | 1 p/time | - | 0.5 | - | in surgery |
| 11 | - | 1+3p/time | - | - | in surgery |
| 12 | - | 2 | - | - | in academic dept |
| 13 | - | 1 | - | yes | - |
| 14 | 4 p/time | - | - | - | - |
| 15 | 5 p/time | 1 | 0.5 | yes | - |

skills and a strong interest in working with other GPs. Because of a shortage of appropriate applicants, however, these criteria were not always met. Several of the MAAGs had fewer facilitators in post than they wanted and some had given up trying to get people who were medically qualified and gone instead for lay support staff. In most places that had them the quality of the GP facilitators was regarded by other respondents as uneven, with descriptions ranging from "superb" to "embarrassingly bad".

*Lay support staff*

Unlike the GP facilitators, the majority of lay support staff were initially employed either to work on specific projects or to service and support the MAAG. The lay support staff

employed by the study MAAGs came from a variety of backgrounds including nursing, practice management, information technology, hospital audit, commerce, industry and education. The formal status of the support staff varied greatly as regards their grading and employment contracts. Some were paid as clerical staff, others had senior manager status within the FHSA. Some were on contracts as short as six months, others were on the permanent staff.

Among MAAG and FHSA respondents there was a general consensus that the calibre and motivation of the MAAG support staff employed in their districts was exceptionally high. (It was suggested that MAAGs had benefited from the fact that they were recruiting staff at a time of relatively high unemployment.) Perhaps because of this, by the time of interview many of the study MAAGs were becoming increasingly reliant on their support staff not only to carry out the day to day administrative tasks for which they had been employed, but also to visit practices, initiate new projects and play a major part in developing MAAG strategy.

*Accommodation*

While the circular acknowledged that MAAGs would require secretarial support and information technology, it contained no recommendations about office accommodation. Nevertheless, among the study MAAGs, all but one had a base of some sort (see Table 6.3). Eight were housed in FHSA buildings and six elsewhere (three in hospitals, two in MAAG members' surgeries and one in the local academic department). These findings are very similar to those of the 1992/93 national survey, which found 2% of MAAGs with no office at all, 46% based in the FHSA, 15% in hospitals, 10% in academic departments or postgraduate centres and the remainder elsewhere (Houghton and Sproston 1995). There were substantial variations in the appropriateness and permanence of the accommodation. Within the FHSA, provision for the MAAG ranged from a desk in a general office to a purpose built suite. Among those outside, one MAAG was housed adjacent to a newly established national centre for audit research, another was in a condemned wooden hut in a hospital car park and a third was about to become homeless again having already had to move five times.

The location of the MAAG office reflected a combination of choice and local

circumstances. In some places the FHSA had no spare office accommodation and the MAAG had to look elsewhere, but most had been offered facilities in the FHSA and the majority had accepted. While there was concern about the danger of becoming too closely identified as part of the FHSA, the advantages of free accommodation and office support and easy access to other FHSA services were generally felt to outweigh the risks. A few MAAGs, however, regarded physical independence from the FHSA as an absolute necessity, irrespective of the poorer quality or higher costs of external accommodation. This was the case for all four of the LMC-led MAAGs that chose not to have FHSA representatives among their members and these subsequently appeared to be the worst housed.

The siting of the MAAG office within or beyond the FHSA had a number of significant effects. Besides the material advantages of lower costs and often better facilities, MAAGs with FHSA bases were significantly less isolated than those outside. Staff in these MAAGs had greater access to support and better contact with other FHSA departments, which appeared to enhance their job satisfaction. The MAAGs themselves were better informed about what else was going on in the FHSA and vice versa. Anxieties about the problems of maintaining confidentiality and about GP suspicion of FHSA links turned out, with experience, to have been unfounded and so the FHSA-based MAAGs became less concerned about these issues. In contrast, the MAAGs that deliberately shunned such FHSA contact missed out on this experience and retained their defensiveness intact.

### *Funding*

#### *Basic allocation*

The circular stated that FHSAs would provide their MAAGs with the resources required to support a programme of practice visits and to provide adequate professional, clerical and secretarial time to enable the MAAG to carry out its responsibilities. No provision was made for direct payment to GPs doing audit. A sum of approximately £12.5 million was allocated to primary care audit each year from 1991-1995. The annual budget allocation for MAAGs was included within the FHSA administrative allocations to regions by the Department of Health. This money was not formally ringfenced, but a banding system based on the size of FHSA districts was used to advise regions of the sum "intended" for audit in each district. The actual value of the three different bands was not

made public. Subsequently some regions chose to adopt their own formulae for distributing funds and ring-fenced the money in passing it on to FHSAs (Beardow 1992). Others gave the FHSAs much more discretion in how they calculated their budget allocations to the MAAGs.

There appear to have been major variations between regions as to how much of the money "intended" by the Department of Health for audit was either included in the allocations made to FHSAs or formally identified within those allocations as audit monies. As a result, some MAAGs received substantially less money than they should have done. In the 1992/93 national survey of MAAGs, the 82 MAAGs for whom figures were available received a total of £5,874,525 out of the £11 million that was allocated to the 96 MAAGs in England and Wales for that year (Houghton and Sproston 1995).

In one of the two study regions, general managers were advised what they were expected to spend on the MAAG and most simply passed on this sum. In the other region there was less direction and managers based their allocations on "back of an envelope" calculations about what the MAAG would need to function. Despite this difference of approach, the ranges of funding to MAAGs in the two regions were very similar. The basic budget allocations of the study MAAGs for 1992-93 are shown in Table 6.4 along with figures from other national studies.

As may be seen, the figures for the study MAAGs are comparable in range to those found in Griew and Mortlock's interview study of 15 MAAGs across the country carried out in 1992, but differ from the findings of the 1992/93 national survey, inasmuch as the range in the latter study was considerably wider. The discrepancy may be partly explained by different ways of calculating the budget allocation (in some districts, respondents to the national survey appear to have included extra sums made available by FHSAs to MAAGs from other sources). It probably also implies that the two regions in the present study were at neither extreme of the national range in terms of how much of the "intended allocation" they passed on to their FHSAs.

**Table 6.4: Study MAAG funding and national comparisons**

| Study MAAGs | Basic allocation for 1992/93 | Direct access to GMS or "slippage" monies to assist practices | Practices can apply to FHSA for audit-related development costs | Regionally funded projects | Office or other costs waived by FHSA | No. of practices |
|---|---|---|---|---|---|---|
| 1 | £69,000 | - | Yes | Yes | - | 128 |
| 2 | £75,000 | - | - | Yes | Yes | 164 |
| 3 | £54,000 | Yes | - | Yes | Yes | 49 |
| 4 | £68,000 | - | - | Yes | Yes | 90 |
| 5 | £45,000 | - | - | Yes | Yes | 39 |
| 6 | £44,000 | Yes | Yes | Yes | - | 54 |
| 7 | £77,000 | Yes | - | Yes | Yes | 108 |
| 8 | £58,000 | - | Yes | - | Yes | 116 |
| 9 | £56,000 | Yes | - | - | - | 78 |
| 10 | £40,000 | - | - | - | - | 40 |
| 11 | £85,000 | Yes | - | Yes | - | 186 |
| 12 | £78,000 | - | - | Yes | - | 147 |
| 13 | £64,000 | - | - | - | Yes | 103 |
| 14 | £75,000 | - | - | Yes | - | 148 |
| 15 | £80,000 | - | Yes | Yes | Yes | 183 |
| Most | £85,000 | | | | | |
| Least | £40,000 | | | | | |
| Mean | £63,000 | | | | | |

Griew & Mortlock (1993) national interview study of 15 MAAGs 1992:

| | |
|---|---|
| Most | £95,000 |
| Least | £40,000 |

Birmingham MAAG national survey 1992/93 (Houghton and Sproston 1995):

| | |
|---|---|
| Most | £163,000 |
| Least | £28,500 |
| Mean | £71,640 |

Among the study MAAGs there was a strong correlation ($r=0.93$, $p<0.001$) between the size of the basic budget allocation and the numbers of practices looked after by the MAAG. This contrasts with the findings from a postal survey of 76 MAAGs carried out in 1992, which found no such association (Griew and Mortlock 1993). Equally, the study findings are at odds with the data from the 1991/92 national survey of funds received by MAAGs in terms of notional £s per GP in each district. These showed allocations varying by a factor of 17.5, between £46 and £807 per GP (reported in Humphrey and Berrow 1994). In the present study, notional £s per GP also varied but by a much smaller amount (between £135 and £405 per GP). Again the explanation for these discrepancies is likely to lie with the major difference between regions as to how the monies were distributed to MAAGs, which, in national studies, would conceal any more equitable methods of allocation that were applied within individual regions.

There was widespread confusion among both FHSA and MAAG respondents about the formula used to determine how much each FHSA was expected to spend on its MAAG. Few respondents knew the principles of the national banding system. None knew how much money the Department of Health intended for districts in each band, nor which band their own district fell into. At the same time, many people were aware of the major variations in funding between districts and different areas of the country.

There were also differences between the study districts as to what the budget allocation was expected to cover. In all cases, the costs of MAAG staff and payment to MAAG members for attending meetings were included. In addition, seven of the MAAGs had to pay all their own administrative costs (see Table 6.4). Elsewhere, as already mentioned, the FHSA subsidised the MAAG by providing accommodation, secretarial support and other running costs free of charge or for nominal sums. Hobbs' (1993) survey of 85 MAAGs carried out in 1993 found, similarly, that just over half were paying their own accommodation charges.

*Additional FHSA funding*

While the budget allocation was not formally intended to be spent on paying practices to do audit, some of the study FHSAs permitted their MAAGs to use some of it for this purpose. Others did not allow spending on practices out of the basic allocation, but gave the MAAG access to additional funds from other sources, most often general medical

services (GMS) monies or non-recurrent "slippage" monies (see Table 6.4). The additional sums available to different MAAGs from these sources varied from nothing to £65,000 (i.e. more than matching the basic allocation). The availability of such funds depended on the attitude of the FHSA and its financial buoyancy. In districts where this money was available, it was generally used either to provide small grants to practices to pay for additional help, to reimburse them for staff time spent on audit or to offer prizes. The money was allocated either through a project bidding system or by advising practices to apply directly to the FHSA for help. As will be discussed later, there were major differences of opinion between the study MAAGs as to whether GPs should be subsidised to do audit in this way and some rejected this option on principle.

*Regional project funding*

In addition to the basic funds allocated through regions, £1.5 million was retained centrally each year (up to 1994) from the primary care audit allocation and MAAGs were invited on several occasions to coordinate bids to the regions for project funding directly from the Department of Health. Between 1991 and 1993, 183 projects were funded nationally in this way (Humphrey and Berrow 1994). At the time of interview, 11 of the study MAAGs had made one or more successful bids for central project funding (see Table 6.4). In some places these projects occupied a major role in the MAAG's strategy and represented a significant addition to their basic funding (up to £56,000 per annum).

The net effect of the variation in costs carried by the MAAG and in the availability and acceptability of the various sources of funds, was that the financial resources of the study MAAGs' varied greatly. Moreover, none of the sources of funding were essentially secure. Non-recurrent monies were both short term and unpredictable, centrally funded projects were time limited and nobody knew whether further bids would be invited in the future and there were widespread doubts about whether the basic allocation would continue to be available after 1994 or whether it would be maintained at present levels from year to year. Some FHSA managers had made it clear to the MAAG that they would do their best to keep the funding up, irrespective of what happened nationally, but others gave no such guarantees.

## Chapter Seven

# THE PURPOSE OF AUDIT AND THE ROLE OF THE MAAG

This chapter begins by outlining the purpose of audit and the function of the MAAG as defined in the MAAG circular and considers how these definitions compare with the views of audit and the MAAG held by respondents in the study districts. (A copy of the circular is included as Appendix D.) The distribution of views between different groups of respondents and the role of each group in determining MAAG policy and practice is then discussed in order to ascertain how the outlook and strategies of the study MAAGs themselves were informed by the various views identified.

### *The purpose of audit*

As discussed in Chapter 4, some broad definitions of the purpose and practice of medical audit were provided in *Working for Patients* and associated policy documents, but these were statements of principle couched in the most general terms, rather than explicit guidelines for practice. The MAAG circular (Department of Health 1990b p.1) reiterated these principles, stating that:

> *"There is a need for all doctors to be committed to medical audit to maintain and improve standards of medical care"* and that *"an effective programme of audit will help to provide the necessary reassurance to patients, doctors and managers that the highest quality of service is being sought within available resources."*

However, it contained no definition of what audit was or how it might be expected to achieve such benefits.

Among respondents in the study districts there was general agreement that if GPs participated in audit both they and their patients might benefit, but there were very different views as to what it was about GPs doing audit that might be beneficial. Analysis of respondents' perceptions of the value of audit, its place in the activities of GPs and its role in relation to wider health service strategies for improving quality, revealed the existence of three distinct ways of thinking about audit which will be referred to here as the *professional*, *practitioner* and *service* views of audit. The key features of each view are summarised below.

*The "professional" view*

This view is the one that comes closest to the "medical" model of audit described earlier and is also the most consistent with the view of audit expressed in the white paper rhetoric and endorsed by the Royal Colleges. It is described here as "professional" because of its linkage with "professional" values.

In this view, audit is seen as the key to improving the quality of medical practice by educational means. Emphasis is placed on audit as a beneficial activity in its own right - rather than simply as a means to an end - because the experience of disciplined and systematic self-scrutiny is itself seen as educational. The focus of attention is on the process of audit, rather than the outcome, because it is assumed that if audit is done properly benefits will automatically follow. Audit is regarded as a professional responsibility for every individual and a collective responsibility of the medical profession as a whole.

To be effective, audit should be voluntarily undertaken, "owned" by the practitioners and, ideally, should permeate every aspect of practice. It should not be imposed or controlled from outside, regarded as an additional activity to be bolted on to normal practice or as a task requiring additional resources or special expertise. An effective programme of audit will produce generic benefits for the health service through ensuring higher quality general practice. In addition, it will help provide the necessary reassurance to the profession itself that it is acting in a professional manner and maintaining high standards and reassure patients and management that responsibility for maintaining clinical quality can safely be left in professional hands.

*The "practitioner" view*

This is a much less idealistic, more utilitarian view of audit. It is described here as the "practitioner" view because it was held by those who saw themselves as advocates for the rights and interests of individual general practitioners, rather than for the quality of the profession as a whole.

In this view, audit is not a key to salvation but simply a practical tool for practitioners to use to follow-up areas of interest or to deal with problems encountered in practice. Emphasis is placed on what audit can achieve for practitioners and their patients and the

many uses to which it can be put, rather than on the value of what can be learned by going through the process. Audit is regarded as a valuable option which every practitioner should feel able to use if they want but not something which should be seen as a professional duty.

To be acceptable and worthwhile, audit should be undertaken voluntarily as and when practices see it as useful and in circumstances where the benefits seem likely to outweigh the costs. An effective programme of audit will improve care by achieving specific benefits for practices and their patients. In addition, it will help defend the shrinking autonomy of individual general practitioners by providing them with an option for action that does not involve either the RCGP, the government or the health authority telling them what to do.

*The "service" view*

The third perspective is described here as the "service" view because it was held by those whose concern was with the quality of care provided by the health service as a whole, rather than primarily with that part which is mediated through medical practice.

In this view, audit is seen as one of a number of methods of improving patient care. It is a method specifically for professional use because it utilises clinical knowledge and access to patients which are not available to other occupational groups such as managers. Emphasis is placed on the benefits to patients which audit can produce and its strategic function in monitoring quality of care and identifying need. The important part of the process of audit is achieving change. Audit is regarded as something which should be part of every health authority's and every practice's strategy for improving care. It should be focussed on areas of importance to patient care. It may need to be voluntary to ensure sufficient commitment among participants to make change happen (though some respondents felt this was not necessary).

An effective programme of audit will help maintain and improve the quality of the health service by supplying the professional element of a larger strategy for quality assurance which involves different occupational groups working together in complementary ways. In addition, by providing an arena for constructive collaboration between profession and management, it will help provide the necessary reassurance to all those concerned for the

welfare of patients that all parts of the health service are working to a common end.

As can be seen, none of these views of audit is essentially incompatible with that put forward in the circular, if only because the circular definition was so general and unelaborated. Between the three respondent views, however, there are important differences of emphasis and some clear points of disagreement reflecting contrasting underlying principles and motivations. Those holding the professional view were committed to the accepted tenets of "good" educational audit, for adherents of the practitioner view the wishes of practices were regarded as sovereign and from a service point of view the primary concern was to use resources effectively to achieve maximum benefit for patients. The implications of these differing views of audit for the work of the MAAG are considered below.

***The role of the MAAG***

The general function of the MAAG as defined in the circular was "to direct, coordinate and monitor medical audit activities within all general medical practices" in its area. The chief objective specified was the institution of "regular and systematic medical audit in which all practitioners take part". The original aim was for all practices to be engaged in audit by April 1992. The circular contained some indication as to how MAAGs should work with practices, what type of audit they should promote and the extent of their responsibilities for monitoring progress and maintaining accountability to the FHSA. However, these suggestions were all in the form of brief general statements rather than detailed operational guidelines. The circular deliberately left ample room for local interpretation on the assumption that approaches would differ from place to place and evolve as experience was gained.

Table 7.1 shows the main provisions of the circular with regard to MAAG strategy and compares these with assumptions about what the MAAG should or should not do in each area from the perspective of the three different views outlined above.

Table 7.1: **MAAG circular, "professional", "practitioner" and "service" views of the function of the MAAG**

## I. WORK WITH PRACTICES

| | **Nature of support to practices** | |
|---|---|---|
| | **MAAG circular** | **"Professional" view** |
| **MAAG should...** | ...concentrate on education and facilitation. | ...concentrate on education and facilitation. |
| **MAAG should not...** | ...expect to provide financial support to practices for audit. | ...provide practical help or financial support to practices for audit, because such help will diminish practitioners' perception of audit as an integral part of their routine work. |

| | **Approach to practices** | |
|---|---|---|
| | **MAAG circular** | **"Professional" view** |
| **MAAG should...** | ...encourage and exhort all practices to participate in audit. | ...encourage and exhort all practices to participate in audit. |
| **MAAG should not...** | | ...force anyone to audit against their will, because involuntary audit will not be effective or educationally beneficial. |

| | **Distribution of support to practices** | |
|---|---|---|
| | **MAAG circular** | **"Professional" view** |
| **MAAG should...** | ...support all practices. | ...support all practices but focus extra help on those with greatest need. |
| **MAAG should not...** | | ...deny help to any practice that wants it, however competent it is at auditing, because there is always more to learn and "good" practices should not be penalised. |

## I. WORK WITH PRACTICES (continued)

### Nature of support to practices

| | "Practitioner" view | "Service" view |
|---|---|---|
| **MAAG should...** | ...provide whatever type of practical help or financial support practices want for audit. | ...provide whatever type of practical help or financial support practices need to audit effectively. |
| **MAAG should not...** | | |

### Approach to practices

| | "Practitioner" view | "Service" view |
|---|---|---|
| **MAAG should...** | ...ensure that all practices are aware of benefits of audit. | ...encourage and exhort all practices to participate in audit. |
| **MAAG should not...** | ...put any pressure on any practitioner to audit, because audit should be an optional choice. | ...waste effort on "hopeless" cases or force them to audit, because audit in such circumstances is unlikely to produce benefits to patients. |

### Distribution of support to practices

| | "Practitioner" view | "Service" view |
|---|---|---|
| **MAAG should...** | ...offer support to all practices, letting focus of effort reflect practice demand. | ...support all practices but focus extra help on those with greatest need. |
| **MAAG should not...** | | ...waste resources on helping practices that are already auditing effectively. |

Table 7.1: **MAAG circular, "professional", "practitioner" and "service" views of the function of the MAAG (continued)**

## II. APPROACH TO AUDIT

| | **Audit methodology** | |
|---|---|---|
| | **MAAG circular** | **"Professional" view** |
| **MAAG should...** | ...encourage regular and systematic audit. | ...encourage practices to set standards and complete the audit cycle. |
| **MAAG should not...** | | ...encourage short cuts. |

| | **Types of audit** | |
|---|---|---|
| | **MAAG circular** | **"Professional" view** |
| **MAAG should...** | ...encourage medical audit. | ...encourage clinical audit. |
| **MAAG should not...** | ...become involved in audit of practitioners' contractual obligations or consider "wider issues of quality". | ...encourage audit of contractual or service issues, because the purpose of audit in such areas is not primarily educational. |

| | **Topics for audit** | |
|---|---|---|
| | **MAAG circular** | **"Professional" view** |
| **MAAG should...** | ...make plans to audit services bridging hospital and community health services and ensure that patients' views and their satisfaction with services are taken into account. | ...initially, encourage practices to do any audit which will provide a positive learning experience...<br><br>...eventually, encourage practices to take on more challenging topics and expand audit into all aspects of practice. |
| **MAAG should not...** | | ...tell practices what to audit, because this would diminish practice ownership. |

## II. APPROACH TO AUDIT (continued)

| | Audit methodology | |
|---|---|---|
| | **"Practitioner" view** | **"Service" view** |
| **MAAG should...** | ...encourage practices to do audit as formally and completely as they feel is necessary to meet their needs. | ...encourage whatever audit process is necessary to achieve beneficial change. |
| **MAAG should not...** | ...criticise anyone's audit methodology. | ...regard "correct" audit process as more important than achieving results. |
| | **Types of audit** | |
| | **"Practitioner" view** | **"Service" view** |
| **MAAG should...** | ...encourage practices to do any kind type of audit they feel will be useful to them. | ...encourage clinical audit, because that is an aspect of quality that the health authority cannot address itself. |
| **MAAG should not...** | | ...take responsibility for organisational or contractual audit which is part of the FHSA's own remit. |
| | **Topics for audit** | |
| | **"Practitioner" view** | **"Service" view** |
| **MAAG should...** | ...encourage practices to audit any topic which matters to them. | ...encourage practices to do audit in areas of importance with evident relevance to patient/health service needs. |
| **MAAG should not...** | ...tell practices what to audit unless they ask for suggestions. | ...encourage audit in areas of idiosyncratic interest to practitioners unless these can be shown to be significant for patients. |

Table 7.1: **MAAG circular, "professional", "practitioner" and "service" views of the function of the MAAG (continued)**

## III. MONITORING AND ACCOUNTABILITY

| | **Monitoring progress** | |
|---|---|---|
| | **MAAG circular** | **"Professional" view** |
| **MAAG should...** | ...keep records of the problems it identifies and the actions it takes to remedy unsatisfactory situations. | ...keep records of MAAG activities. |
| | ...include evaluation of the audit exercise itself in the arrangements made for audit. | ...seek information from practices about the range of audit activities and progress round the audit cycle. |
| **MAAG should not...** | | ...require practices to provide information about their audit results. |

| | **Reporting to the FHSA** | |
|---|---|---|
| | **MAAG circular** | **"Professional" view** |
| **MAAG should...** | ...provide a regular report on the general results of the audit programme. | ...provide FHSA with aggregated information about practice levels of audit activity and progress round the audit cycle. |
| **MAAG should not...** | ...provide identifiable details about individual doctors or their patients. | ...provide information to FHSA about individual practices. |

| | **Coordination of strategy with FHSA** | |
|---|---|---|
| | **MAAG circular** | **"Professional" view** |
| **MAAG should...** | ...hold joint discussions with the FHSA general manager to agree the programme and scale of medical audit activity. | ...maintain independence from the FHSA with regard to MAAG strategy. |
| **MAAG should not...** | | ...take account of FHSA interests unless they coincide with MAAG perceptions of what is important. |

## III. MONITORING AND ACCOUNTABILITY (continued)

| | **Monitoring progress** | |
|---|---|---|
| | **"Practitioner" view** | **"Service" view** |
| **MAAG should...** | ...keep records of MAAG activities. | ...keep records of MAAG activities. |
| | | ...seek information from practices about topics audited and change achieved. |
| **MAAG should not...** | ...ask practices for information about their audit activities. | |

| | **Reporting to the FHSA** | |
|---|---|---|
| | **"Practitioner" view** | **"Service" view** |
| **MAAG should...** | ...provide sufficient information to confirm that the MAAG is using its resources for the purposes intended. | ...provide information on topics audited, change achieved and individual practice needs. |
| **MAAG should not...** | ...provide information to FHSA about individual practices. | |

| | **Coordination of strategy with FHSA** | |
|---|---|---|
| | **"Practitioner" view** | **"Service" view** |
| **MAAG should...** | ...maintain independence from the FHSA with regard to MAAG strategy. | ...take account of FHSA concerns in planning MAAG strategy. |
| **MAAG should not...** | ...take account of FHSA interests unless practices request help in those areas. | |

As may be seen, there are some areas of overlap between the different approaches and all have some features in common with the recommendations in the circular. However, each approach, if followed consistently, would produce a very different audit programme on the ground in terms of what the MAAG would do for practices, what audit practices would be expected to do themselves and the extent of management involvement.

In fact, few of the study MAAGs adopted a course of action which was entirely consistent with any particular line of thinking. In some districts there was consensus between all those involved about what the MAAG should do, but in many places there was less than complete agreement either within the MAAG or between MAAG and FHSA. While most respondents held personal views which could be clearly identified with one or other of the approaches outlined, few expected their MAAG strategy to reflect that model in pure form because they were aware of competing perceptions held by other stakeholders and the need to make tactical compromises. The distribution of views between respondent groups and their respective importance in determining the policy and practice of the study MAAGs are considered below.

***Respondents' views of audit and the MAAG***

*MAAG chairs*

The great majority of MAAG chairs, including all those with academic or RCGP links, held a professional view of audit and the MAAG. At the same time, all of them were aware of potential pressure on the MAAG from managers to take account of service interests and to cooperate more closely with the FHSA. Some had already experienced such pressure. Certain demands, none of the chairs were prepared to countenance. For example, none were willing to force practices to audit particular subjects on behalf of the health authority and none would provide information to the authority on individual practices. Both these were regarded as matters for instant resignation. However, the chairs varied in the extent to which they felt the MAAG could accommodate more moderate requests by management.

On the one hand, there were a few who saw the professional and service perspectives as genuinely complementary and potentially inseparable:

> *"It is essential to take a population approach to providing care. Whatever work*

*is done has got to be done against the backcloth of overall directives such as those in the Health of the Nation - the population approach. Other groups would benefit from the data obtained by the MAAG. There is a need to work together with public health etc. - this will have to come." (C1)*

These chairs tended to be people who already had experience of working with the health authority and had developed considerable personal sympathy with the authority's objectives. Often, they had been encouraged onto the MAAG by general managers because of their positive views.

At the opposite end of the scale, there were others who were profoundly critical of NHS policy and deeply sceptical about central government commitment to the welfare of patients. These doctors saw the opportunity to bypass the concerns of the health authority as one of the most important aspects of the audit initiative. They wanted nothing whatsoever to do with the service perspective, seeing the MAAG rather as a vehicle for use in opposition:

*"I hope that we can be involved in the discontinuation of the ideas that are prevalent at the moment - such as some of the things in health promotion."(C2)*

Between these two extremes was a larger more neutral group of chairs who acknowledged some legitimacy in the service view of audit, but saw educational audit and management concern for health service quality as essentially separate arenas of development. These chairs had no great objection to the MAAG assisting practices in areas that were of interest to the FHSA, so long as this audit was freely undertaken and both confidentiality and educational principles could be protected. To ascertain the areas in which this might be possible, requests from the FHSA would have to be considered on a case by case basis:

*"The FHSA has the right to make any requests it wants and the MAAG would be silly not to debate them, but it has to come to its own decisions. What we must not do is be slavish and say that anything the FHSA suggests must necessarily be wrong."(C12)*

Beside their awareness of the service orientation of the managers, professionally orientated MAAG chairs were also aware that not all practices shared their exalted view of audit and recognised that many would be more interested in obtaining help from the MAAG to meet their obligations to the FHSA or to get audit out of the way as painlessly as possible than in undergoing a good educational experience. Some chairs, especially

those with senior positions in the RCGP or universities, were not prepared to compromise their educational principles and saw the MAAG as having a responsibility to insist that practices audited properly from the start. Others were much more pragmatic about the need to gain good will and regarded it as quite acceptable for the MAAG to begin by helping practices with projects that did not even pretend to be educational such as auditing their claims for clinic payments.

A minority of chairs were much more explicitly committed to the practitioner view of audit. Those who took this view came mainly from inner city districts with low RCGP membership and large numbers of single-handed GPs. They saw themselves as defenders of their beleaguered constituents against an elitist Royal College which did not understand or sympathise with the problems of ordinary practitioners and a health service ruining their lives (and those of their patients) with the unreasonable demands of the new GP contract and other initiatives:

> *"In this area there is a high mortality rate from cardiovascular disease and diabetes. You cannot blame GPs for this high incidence. There is a lot unknown and you cannot be sure that if you check the blood pressure etc. as required in Health of the Nation that it will make any difference. There is no evidence that this would be certain. But one thing that you can be sure of is that if you over stress the doctors any more then there will be a higher mortality rate amongst doctors. I have never seen it as a statistic but I am quite sure that it is an issue."(C11)*

The chairs' views of audit were a key influence on MAAG policy because they generally put far more time into the MAAG than other members did and took the lead in making plans, writing policy documents and negotiating with the FHSA and other outside bodies. Among the study MAAGs, the only places where the chairs appeared to be less important were Districts 7 and 9. In the former, as mentioned earlier, the chair had been chosen by the general manager primarily as a politically appropriate figurehead and much of the strategic leadership came from the medical adviser. In the latter, the chair had become leader of the group by default rather than personal design and, although she did much of the MAAG's work, she allowed strategic issues to be determined by other members whose views were much more vehemently anti-FHSA than her own.

*GP facilitators*

As mentioned earlier, eight of the study MAAGs employed one or more general

practitioners who were not MAAG members to work with practices on a part time basis. This group is under-represented in this study, because of the decision which was taken to interview full time lay support staff rather than GP facilitators where there was a choice. Consequently, the views given here are based on four interviews only.

Perhaps not surprisingly, given their occupational identity as clinicians and the pedagogic role for which they were appointed, the GP facilitators who were seen all favoured the educational emphasis of the professional view of audit. At the same time, however, because of their acute awareness of the practical difficulties faced by many of the practices they visited, they were often more relaxed than their respective MAAG chairs about giving practices substantive help.

All the GP facilitators played an important part in practice visits. In four of the 15 study districts (2,4,5,14) they were the only direct point of contact between practices and the MAAG. Thus they had a key role in representing and interpreting MAAG strategy on the ground. On the other hand, GP facilitators were not generally expected to attend MAAG meetings or to contribute to policy development. The four who were interviewed were all quite clear that their job was to act on behalf of the MAAG rather than make decisions and they appeared to be quite happy with this role, having deliberately chosen in applying for the job to act as "doers" rather than planners. Although the experience of trying to implement MAAG strategy had given them strong opinions about what was needed, none had made overt attempts to influence their MAAG's policy and none of them wanted to become members of the MAAG.

*MAAG support staff*

As mentioned earlier, 11 of the study MAAGs employed lay support staff. Coming from a wide variety of occupational backgrounds within and beyond the NHS this group had no shared professional affinity for any particular approach to audit. Rather the views of individual staff appeared to be formed in response to the dominant ethos of the MAAG for which they worked and the experience gained from their own contact with practices and the FHSA.

Some support staff, such as those in MAAG 12, held views that were indistinguishable from those of their employers. These two staff were based in an academic unit and had

no significant contact with the FHSA or with practices because they did not do practice visits. They had encountered nothing to suggest that the rigorous professional approach promulgated by the MAAG chair was inappropriate or ineffective and they were as resolutely committed to the professional line as anyone. Others, such as the coordinator employed by MAAG 11, took a rather more independent line. MAAG members in this district were committedly non-directive in relation to practices and extremely negative about service issues. The coordinator was aware that the FHSA was critical of the MAAG's approach and was himself unhappy with its refusal to respond to practice requests for leadership or to explore opportunities for common cause with the FHSA. Having started out with a belief in the professional approach to audit, he was now thoroughly disillusioned, regarding the MAAG's stance as an excuse for inaction and a barrier to constructive action and seeking to subvert it wherever he could. Generally, where staff views diverged from those of the MAAG GPs, they did so in the direction of greater sympathy for service interests and the practical needs of local practices.

In seven of the districts where lay support staff were employed, these staff undertook a significant and increasing proportion of practice visits. In this respect they had a similar function to the GP facilitators of communicating and interpreting MAAG policies to the practices. Unlike the GP facilitators, however, all lay support staff employed by the study MAAGs also attended MAAG meetings and worked full time for the MAAG. Their influence on MAAG policy varied depending on the status they were accorded within the MAAG and the balance between their own energy and initiative and that of the MAAG members.

In a few places the support staff did not appear to have thought of making suggestions. One co-ordinator had done so and her proposals had been turned down.
Elsewhere, however, lay staff were working in close partnership with the MAAG chair or other key decision makers, as the chair of MAAG 8 describes:

> *"Between you, me and the gatepost, D. [the lay coordinator] and I find the MAAG a bit of a nuisance. We two work well together. We've been given a free hand. We write the newsletter. We decide on strategies and then every now and again we have to piece it all together and have it discussed by the rest of them. It's a shame - they should have more of an input. But we set the agenda and nobody else ever puts anything on it."(C8)*

One or two lay employees had gone further still and were effectively running their

MAAGs single-handed. In District 6, for example, the lay coordinator (an ex-NHS management trainee) was not only organising most activities from day to day but also setting the MAAG's agenda, controlling the finances and drafting the annual report. As she said, and her chair acknowledged, *"my strategy pretty much drives things"*.

*Medical advisers*

Given the unusual occupational role of medical advisers, their views of audit might be expected to be more complex than those of the groups so far described. All but two of the advisers had themselves been general practitioners until quite recently (the two exceptions both came originally from public health) so they shared a common professional background with most MAAG members. However, they had all taken the exceptional (and, to many of the other GP respondents, incomprehensible or even treacherous) step of leaving general practice to work for the FHSA. Once there, they had all, to a greater or lesser extent, embraced the population perspective of public health and the management priorities of the NHS.

In fact, the medical advisers' views on audit were quite consistent - all were basically committed to the service view. In some cases their personal experience of general practice was reflected in a more tolerant attitude than that of their general manager colleagues towards the independent and cautious stance adopted by most MAAGs. This was especially true of the minority who had been specifically invited by their GP colleagues to become MAAG members. More often, though, medical advisers' inside knowledge appeared to heighten rather than temper their frustration with the MAAG's insularity. Those medical advisers whose MAAGs had explicitly excluded them from membership were the most frustrated and critical of all.

For the majority of medical advisers who were also MAAG members, their dual role put them in a unique position to identify complementary issues, overlaps and mismatches in the MAAG and FHSA agendas and many could see much potential common ground. At the same time, medical advisers were only tolerable as members of the MAAG on condition that they maintained an absolute separation between their two functions and did not use knowledge gained from being on the MAAG when on FHSA business. While reluctantly acknowledging the political necessity of this internal "Chinese wall", most advisers regarded the MAAGs' preoccupation with confidentiality as excessive and

counter-productive insofar as it created inefficiency and emphasised conflicts of interest with the FHSA where these did not really exist:

> *"The problem is that the MAAG has only looked at the potential harm that may come about from sharing things - they have not looked at the benefits. It is in everybody's interest to help develop a better service, and this is particularly important in primary care at the moment because it is important to start taking on some things which are traditionally done in hospital but could be better done outside. Potentially this may be cheaper and provide a better service to patients. It may also be more satisfying for GPs. Audits the MAAG is not sharing with us may help in this development - I think they are missing out on those opportunities."(M14)*

Despite their strong views about audit and the MAAG, most medical advisers who were MAAG members felt constrained by the awkwardness of their position from voicing these too strongly or trying to influence MAAG policy directly. Many chose rather to cultivate a slightly detached position as a source of advice on technical issues or provider of particular skills. The exception was in District 7, where the medical adviser had played a crucial part in setting up the MAAG and was still highly influential. Outside MAAG meetings, however, several of the medical advisers had developed strong working relationships with MAAG support staff, especially those based in the FHSA, by involving them in quality related work beyond the MAAG. The alliances thus constructed were creating important bridgeheads for the introduction into the MAAG of more service oriented views.

*FHSA general managers*

All the general managers acknowledged the professional emphasis in audit policy and accepted that allowances must be made for this, at least in the early days. Like the medical advisers, however, the great majority of them were looking for the development of a more service oriented approach in the future with the MAAG working, at least in part, to an FHSA agenda. However, they varied in how sharp a shift in emphasis they were looking for and how long they expected it to take.

Some managers wanted greater influence over their MAAGs as soon as possible simply because they disliked like not being in control. They felt they had the right as managers to influence the activities of any sub-committee of the FHSA which received authority funds and saw no good reason why GP audit should be treated differently. These

managers, who often had a fairly combative relationship with their local GPs already, saw nothing to be gained by being patient and little to lose by pushing hard. One such manager (G7) attempted to negotiate greater leverage over the MAAG by giving it control of an extra £50,000 of FHSA money, others kept up the pressure on the MAAG by constant requests for collaboration.

In contrast, there were other managers who, while clear about what they wanted from the MAAG in the end, prided themselves on their understanding of general practice culture and were convinced of the benefits of allowing the MAAG to take the lead and evolve at its own pace:

> *"It's got to be the docs themselves that are running it. If they think it's a managerial tool then they'll walk away. The more it's seen to be separate from the FHSA the better. I'd like medical audit to be part of identifying where we can make improvements, to inform the debate we are starting to have on how to invest more money in primary care. I would hope that the MAAG could identify opportunities and also help evaluate the effects of investing money. I'm looking for pressure coming out of the MAAG - not simply reporting, but positively proposing things to us. But I'm anxious about threatening them. I can see them being very twitchy. I think we've got to be careful about being too clever too quickly."(G4)*

Most managers assumed that the MAAG would need a free hand for a couple of years at least to get audit off the ground among local practices. After that it was hoped that the confidence and good will built up would make it progressively easier - as it would become increasingly important - to persuade the MAAG to accept a more collaborative role. There were, however, a few who were committed to an independent, professionally orientated MAAG, not just as a short term tactical necessity, but as a matter of principle:

> *"I am not relying on the MAAG to provide me with answers to problems, or to tell me what I should be looking at, or to set quality standards. In short, I am not looking for the MAAG to make a contribution to the service. I am looking for the MAAG to make a contribution towards improving professional expertise and the practice of practitioners in this district. It is not the individual audit topics that are going to be the real asset, it will be that you produce practitioners who challenge themselves about what they are doing."(G12)*

This manager explained that he had been "indoctrinated" by the local professor of general practice, whom he much admired. The two other general managers (6 and 15) who held such views appeared to have been similarly persuaded by senior local GPs.

As described earlier, most managers had no direct personal involvement as MAAG

members after the period of original setting up. However, almost all of them had regular informal meetings with their MAAG chairs and were thus in a good position to make their views known. While the majority required their MAAGs to provide a costed business plan, none had so far used this to significantly steer MAAG strategy except, as already mentioned, by providing extra money for specific purposes, but several had indicated that they would expect more input in the future and that MAAG funding might depend on how this was received.

*Other stakeholders*

The views of other MAAG members - including GP members and representatives of hospital audit and public health - were not ascertained directly in this study. As with the GP facilitators, this omission reflects the decision to concentrate on those stakeholders thought likely to have the greatest influence on the MAAG. MAAG respondents were not asked systematically about other members' views of audit or the MAAG but often they were mentioned voluntarily.

The impression gained in most districts was that the views of the majority of ordinary GP members had relatively little impact, either because MAAG policy was dominated by those with more central roles or because members' views did not significantly differ from those of the MAAG chair. Where individual members' views did appear to be influential was in those places where the MAAG was run as a more co-operative venture and the main respondents were relatively flexible and open-minded about accommodating service interests. In these places, individual members with entrenched professional or practitioner views of audit were sometimes complained about in interviews for acting as a brake.

As far as the representatives of other medical specialties were concerned, public health physicians might be expected to hold a more strongly service view of audit, while the views of hospital doctors might be anticipated to be closer to GPs. From the little that other respondents said about them, this seemed to be the case. Whatever their views were, however, neither category of member appeared to have a major influence on the study MAAGs. Often they were irregular attenders at MAAG meetings and none were involved directly with practices. They were generally portrayed by respondents as behaving like observers rather than active participants in the MAAG.

The final set of stakeholders whose views might be expected to influence MAAG policy are those of the local practices themselves. A direct survey of what local practitioners thought was beyond the scope of the present study and therefore no information is available for the study districts as a whole. However, four of the study MAAGs (1,6,10,12) had themselves surveyed their practice populations to find out what they thought about audit and what they wanted from the MAAG. The findings of these surveys provide some limited indication that practices were less committed to professional principles, less concerned to audit their own idiosyncratic interests, less hung up about independence from the FHSA, more willing to share their results and more positive about audit generally than many MAAGs perceived them to be. For example, of those surveyed in District 10, 67% wanted help with audit of chronic disease management and 34% wanted to participate in inter-practice or district-wide audits based on agreed protocols. Of those surveyed in District 1, only 5% cared whether or not the MAAG was based in the FHSA or not. The MAAGs that did such surveys took notice of their findings, but most MAAGs did not have such information and acted instead on the basis of their own perceptions of their practices wants and needs.

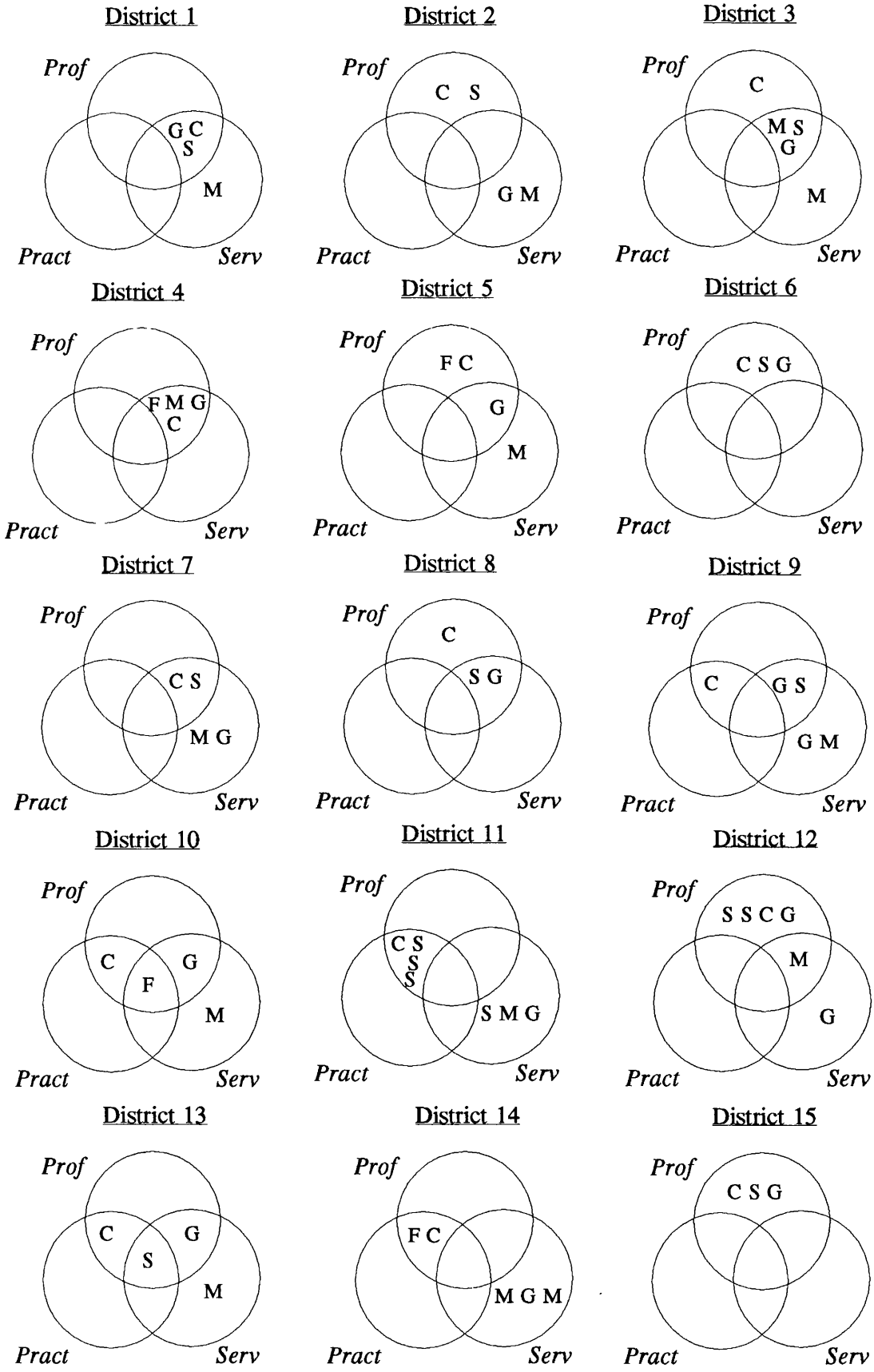
*District configurations of views of audit and the MAAG*

Figure 7.2 puts together the various respondents' views of audit and the MAAG for each of the study districts. For each district, there are three interlocking circles representing the three different views of audit described earlier. Each respondent is represented on the figure by a letter denoting their category (e.g. M = medical adviser). Each letter is located within the circle which most accurately represents that person's views. Where a letter is located in the overlapping area between two (or three) circles this indicates that the respondent concerned felt the MAAG should take account of both (or all three) of the views involved.

The figure shows variation between districts in the distribution of views, the willingness to compromise and the degree of consensus between respondents. As will be seen in the chapters which follow, the way in which stakeholder views were configured locally was an important influence on what each MAAG actually did and on respondent satisfaction in different districts both with their local MAAG and with the policy on audit at a national level. But views as to what the MAAG should do were not the only determinants of what happened in practice. What went on in each district was also significantly

affected by the practical constraints and opportunities of the local situation including the skills, capacities and resources of MAAG members and other factors discussed earlier such as distance, demographic characteristics and available funds.

Figure 7.2: Respondent views of audit and the MAAG by District




C = MAAG chair; S = lay support staff; F = GP facilitator; M = medical adviser; G = general manager

*Prof = professional; Pract = practitioner; Serv = Service views of audit*

## Chapter Eight

# ACTIVITIES OF THE STUDY MAAGS

This chapter describes how the study MAAGs actually went about "directing, coordinating and monitoring medical audit activities" within the practices in their districts. The findings are organised under three main headings which correspond to those presented in Table 7.1 in the previous chapter. They are: Work with practices, approach to audit and monitoring and accountability.

## WORK WITH PRACTICES

Each MAAG had to decide what type of support to provide to practices, how to distribute it between them and what to do about practices who did not want to cooperate. These aspects of their work are considered here in turn.

### *Nature of support*

Table 8.1 shows the wide range of activities undertaken by the study MAAGs for the purpose of promoting audit and the great variation in their programmes of work. Many of the activities were undertaken by well under half the MAAGs and none of the MAAGs had adopted strategies which matched in all respects. In fact, the variation was much greater than the table shows because, as will become clear, the content and importance of activities listed under a common heading was often very variable on the ground. The table also shows changes in activity over time.

There were some consistent trends, such as the move towards fewer MAAG members doing practice visiting and more training in audit for primary health care staff. But not all the developments were convergent, for example one MAAG was putting major effort and funds into raising its profile locally by establishing a newsletter while another had recently given up producing one on the grounds that nobody read it.

**Table 8.1: Study MAAG activities for promoting audit**

| Activity | Study MAAG 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|---|
| *Practice visits* | | | | | | | | | |
| MAAG members visit | S | * | * | - | - | * | - | * | S |
| GP facilitators visit | P | * | S | * | * | - | * | * | - |
| Support staff visit | * | * | * | - | P | * | * | - | * |
| *Practical assistance* | | | | | | | | | |
| Funds to do audit | - | * | - | * | * | * | - | * | * |
| Funds for development | - | - | * | * | - | P | - | * | - |
| Equipment loaned | - | - | - | - | * | - | - | - | - |
| Prizes for audit | - | - | - | * | - | - | * | - | - |
| MAAG staff help | - | * | * | - | - | - | * | - | * |
| *Audit training* | | | | | | | | | |
| GPs | * | - | - | * | * | - | * | - | * |
| Practice nurses | * | * | - | - | - | - | * | * | * |
| Practice managers | * | * | * | - | - | - | * | - | * |
| *Group work* | | | | | | | | | |
| Interpractice audit | * | * | * | * | * | * | * | * | - |
| Interface projects | 6 | - | 4 | - | - | 1 | 1 | - | - |
| Centrally/regionally funded projects | 4 | 1 | 5 | 1 | 1 | 4 | 2 | - | - |
| *Information services* | | | | | | | | | |
| Newsletter | - | S | * | P | - | - | * | * | - |
| Audit pack to practices | * | - | - | - | - | * | * | - | - |
| Sample protocols | * | - | * | P | - | * | - | - | * |

KEY: P = planned; S = stopped

**Table 8.1: Study MAAG activities for promoting audit (continued)**

| Study MAAG 10 | 11 | 12 | 13 | 14 | 15 | Current total out of 15 | Activity |
|---|---|---|---|---|---|---|---|
| | | | | | | | *Practice visits* |
| * | S | S | * | - | * | 7 | MAAG members visit |
| * | - | - | - | * | * | 8 | GP facilitators visit |
| - | * | - | - | - | - | 7 | Support staff visit |
| | | | | | | | *Practical assistance* |
| * | P | - | * | * | - | 9 | Funds to do audit |
| - | - | - | - | - | * | 4 | Funds for development |
| * | - | - | - | - | - | 2 | Equipment loaned |
| - | - | * | - | - | - | 3 | Prizes for audit |
| - | * | - | - | * | - | 6 | MAAG staff help |
| | | | | | | | *Audit training* |
| - | * | - | * | * | * | 9 | GPs |
| * | - | - | - | - | * | 7 | Practice nurses |
| - | - | - | - | P | * | 6 | Practice managers |
| | | | | | | | *Group work* |
| - | * | * | * | * | * | 13 | Interpractice audit |
| - | 1 | - | 1 | - | 2 | 7 | Interface projects |
| - | 1 | 1 | - | 1 | 4 | 11 | Centrally/regionally funded projects |
| | | | | | | | *Information services* |
| - | * | - | * | - | * | 6 | Newsletter |
| - | P | P | - | - | - | 3 | Audit pack to practices |
| * | - | - | - | - | * | 6 | Sample protocols |

*Practice visits*

Visits to individual practices were mentioned in the MAAG circular as a likely MAAG activity and were seen by all but one of the study MAAGs as a major focus for the MAAG, at least in the early days. The one exception (MAAG 12) had decided against doing visits to all but a few practices with particular difficulties, because it regarded universal visits as an inefficient use of MAAG time. For the rest, however, completing the first round of visits was the key, and often the only explicit or measurable, objective for the first year of the MAAG's existence. At the time of interview, the vast majority of practices in all the study MAAG districts (except MAAG 12) had been visited at least once and in 11 of the districts a comprehensive second round of visits was underway.

In the early days all the systematic visits were undertaken by MAAG members, GP facilitators or both. Lay support staff, where they existed, were sent in to follow-up on technical issues or did not visit at all. In many districts this pattern persisted at the time of interview, but in five of the MAAGs (1,3,6,9,11) arrangements had changed and lay support staff were participating in the main visiting programme or had taken it over entirely. In some places this had come about by default because the members had effectively given up on their visits:

> *"We did some visits early on. Since then we have left it to the support staff. I think the reason is that GPs were very over-hassled by the contract, and members are also members of other things. I don't know whether it is time or energy - whichever, it is difficult. There was quite a reluctance by members to continue with the visiting."(C11)*

Elsewhere, the change in focus was a more positive decision in response to the preference expressed by practices where they were offered a choice:

> *"Our concern at first was that they would want doctors going in, but our impression has been that they prefer to have a non-medical expert." [Why is that?] "A lot of the audit is done by the practice nurses and clerical staff, since a lot of the audit is about measurement, so the doctors think it is better to have someone talking to the staff. Also some of the doctors find it easier to talk to somebody who knows about the nuts and bolts of doing audit - she [the lay coordinator] understands it better. She's very good at conceptualising. Also, she's not so likely to be seen as critical clinically of anyone who's a doctor."(M3)*

Both the style and quality of the practice visits were affected by the skills and attitudes of those who did them and these varied between the three potential categories of visitors. In the appointment of GP facilitators and lay support staff some consideration had usually

been given to their knowledge of audit, skills in facilitation or interest in visiting practices. For MAAG members, this was less often the case. While almost all GP facilitators had received some form of training - albeit often rudimentary - in how to work with practices, few members had been given any training at all. While the GP facilitators were paid specifically to do visits, most members were not (usually they were paid an annual retainer or on the basis of MAAG meetings attended).

Not surprisingly, therefore, while some members were motivated, competent and confident, others had none of these attributes. As the lay co-ordinator in MAAG 6 put it:

> *"Some members are very good, some have good days and bad days, and some have quite a few bad days."(F6)*

In comparison, both GP facilitators and lay support staff appeared to be much clearer about their role in visiting practices, less diffident and more concerned to be seen to be doing the job effectively. In addition, support staff were much more likely to work actively with other members of the team within the practice and often more willing to roll their sleeves up and help, because they did not identify so strongly as the doctors with the idea of being part of an advisory peer group.

*Practical assistance*

As well as giving advice to the practices about how and what to audit, the MAAGs had to decide how much and what kind of practical support, if any, it was appropriate to offer. It was widely understood that the funding for general practice audit was not intended to include payment to practices for doing audit and the MAAG circular contained no suggestion that practices should receive assistance with their audit activities except for educational facilitation.

The initial assumption of most of the study MAAGs, in line with the professional view of audit, was that providing any kind of practical help was potentially dangerous because of the risk of undermining practice ownership of audit or encouraging people to see audit as an add-on activity which needed extra money. At the same time it was obvious early on that lack of resources was seen by many practices as an obstacle to doing audit and that many would appreciate some help. It also quickly became apparent from practice visits that some practices lacked the necessary infra-structure for audit, including such

basic precursors as age-sex registers and accessible notes and were therefore in no position to begin auditing even if they wanted to.

By the time of interview, almost all the MAAGs had modified their approach and developed ways of enabling practices to obtain funds - albeit quite small sums - for audit or audit related activities. Nine of the MAAGs were offering funds specifically for audit, usually by inviting practices to make bids for projects. In addition, four MAAGs had negotiated arrangements whereby requests from practices for development monies for staff or equipment for audit would be looked on particularly favourably by the FHSA.

The initial idea of paying practices for audit appeared often to have come from the FHSA - the general manager in District 7, as mentioned earlier, had given the MAAG £50,000 from the general medical services budget explicitly for this purpose. Others offered their MAAGs the opportunity to use up any underspend in this way. Some MAAGs had been forbidden to use their own budget allocations but had been given access to one-off end of year leftovers from various unspecified FHSA sources.

Whatever their initial qualms, all the respondents whose MAAGs had started offering money in one form or another were convinced that this was helpful in bringing practices on board:

> *"The very first visits - going out to see the practices - a lot of the doctors said "Yes, well it's all very well, but I don't have the time, I don't have the staff." So we said: "If we take that constraint away, what do you feel about it then?" They said: "Well I'd certainly consider it, I've been interested in doing....for ages." When we have been able to say to practices we can offer help - for example with postage or to account for the receptionist's time - their eyes have lit up. They have got interested."(F3)*

With hindsight, the dangers of creating dependency were regarded as insignificant compared with the, largely symbolic, incentive provided by the small sums offered (£60 - £500). Moreover, for some MAAGs it was evident that "having something to offer" made a considerable difference to their own sense of legitimacy:

> *"It is the same sort of approach as when 19th century missionaries took their glass beads out with them. It is the free gift to aid discussion. It is one way round what might look to them like you are going in to try to sell something which will have cost implications to them."(C10)*

The giving of money was also seen as a justification for requiring higher standards of

audit - even the most diffident and low key MAAGs made it clear that grants were only given for "real" audit and that the MAAG would definitely want feedback on what was done with the money. It is perhaps no coincidence that the five MAAGs which stood out against the giving of money for audit included all those with academic leadership, which appeared to be linked to greater confidence in their educational role as well as a more uncompromising commitment to the professional approach.

An alternative to making funds available to practices to support their audit projects was for the MAAGs themselves to provide practical assistance with pulling records, setting up disease registers and structuring and summarising notes. Six of the MAAGs were providing some such help and one had actually specified its willingness to do so in its business plan. The majority were, however, careful to avoid being seen as a source of practical support:

> *"They would like us to arrange and do the audit in their practices. We have to say no to them and that they have to arrange and do the audit themselves. We might give funds and help - medical students for example - but we will not run the audit for them. It is not rent-an-audit, the audit has to be owned by those doing it."(C13)*

While the official justification for not helping out was that it would undermine ownership, it was clear that many of the MAAGs did not object to the practices getting such help from other sources. Some openly admitted that they were "telling the practices sneaky ways to get their audit done for them" which included, for example, calling in the nurse audit team from the FHSA. The real issue appeared to be more about how MAAG members and staff saw their own role in relation to the practices. The GP facilitators, in particular, were clear about the limits of their responsibilities as mentors and advisers, even where the need for assistance was obvious:

> *"I have visited a wonderful single-handed practitioner and he is floundering: His list size is growing because he is popular but he has not got a clue about management. I have told him to do an age-sex register and that would be half way there. He just looked at me. He needs an assistant to get this up and running and he cannot afford to buy any more receptionist time. He does need extra help, but I cannot do more until the bread and butter is working properly."(F14)*

In contrast, most of the lay support staff who visited practices acknowledged that they did sometimes go in and help directly when they saw a need. In their case, the main reason given for not doing more of this was simply lack of time.

*Education*

Ensuring the availability of training courses in medical audit for GPs was identified in the circular as an essential task for MAAGs. It was anticipated that this would involve consultation with local postgraduate educational bodies and that GPs would be able to claim Post-Graduate Education Allowance payments for attending such courses.

Most of the study MAAGs had arranged some sort of collective educational activities for local GPs but the nature, amount and apparent success of what they provided varied greatly. At one end of the scale were groups such as MAAG 1:

> *"They have about four big seminars a year, monthly lunch-time meetings, consensus working group meetings and standard setting meetings. They also have six-monthly patch meetings as well, which is basically a way of introducing MAAG to the rank and file."(G1)*

At the other end stood MAAG 9 which, at the time of interview, had made only one abortive attempt at an educational meeting:

> *"They [the MAAG members] said they did not want any more workshops - the one they had done had been awful, the attendance had been awful, the feedback had been awful, and they did not want any more."(F9)*

As might perhaps be expected, those MAAGs with a stronger background of involvement in education - either through the RCGP or universities - tended to place greater emphasis on training and were more organised and confident in what they were doing.

Despite the recommendations in the circular, the one common characteristic of all the study MAAGs' training activities for GPs was the lack of coordination with other local educational programmes. As mentioned earlier, MAAGs were expected to have substantial educational representation among their membership including Regional or Associate Advisers in General Practice, staff from a local university department or GPs with a local educational function and all the study MAAGs had one or more such members. In practice, this cross-representation was of variable significance. A few keen individuals worked actively to build connections, but the great majority of "educational" members appeared to occupy their various roles without developing any links between them. As a result, none of the MAAGs had any regular formal input to or from programmes of continuing education for GPs. At the same time, many of them were aware that practices were getting uncoordinated and sometimes contradictory educational input about audit from a variety of other sources including the RCGP, health authorities

and pharmaceutical companies:

> *"There's a slight tension - and indeed competition - because of the work of the RCGP audit fellows. They have produced a wide array of standards, which I think are fine. But they are for enthusiasts, and not accepted by non-enthusiasts. There's a tension between what is the role of the MAAG and what is the role of these fellows. Also you've got the backlash of drug companies coming into practices with audit tapes. You go into practices and they say: "I know all about audit because Allen & Hanbury came in." Some of them are good and some aren't. It's like everyone's getting on the audit bandwagon and there's a saturation point. But is one better than the other? I don't know - their meals are definitely better."(C1)*

Besides the courses, workshops and study days put on for GPs, almost half the study MAAGs had begun to provide training in audit for other members of the primary care team, particularly practice managers and practice nurses. In every case, the initiative for such developments appeared to have come from lay support staff and the courses were generally run by them, either on their own or in conjunction with FHSA staff development teams. To most MAAG support staff, developing the audit skills of practice staff was an obvious priority since they were the ones who actually did the work of practice audit and were often keener than the GPs to get involved in audit. While many MAAG chairs shared this view, some were concerned that such an expansion of their remit might actually put GPs off, especially if they were expected to participate in team-based learning with their practice staff. In several places it appeared that support staff had gone about setting up courses without the active support of the MAAG members and in one case the members had actively blocked such a development.

Attitudes apart, the main constraint on providing primary care team training was that the MAAGs had no established means of reimbursing practices for time spent by their staff in audit education. While all the MAAGs had made arrangements for GPs to claim PGEA payments for their training, such a scheme was not available for practice staff.

*Group audit projects*

Although nothing was said in the circular about inter-practice audit projects, thirteen of the study MAAGs had set such projects up and these appeared to be have been very popular:

*"There has been hammering on the doors to get into particular audit groups and people have been turned down."(S6) "We only wanted eight practices, and 76% said yes!"(S3)*

However the extent of such activity varied considerably from a single joint audit on asthma involving just three practices to MAAGs with four or five district-wide projects supported by substantial additional research funding and employing dedicated project staff. In Districts 9 and 10 the MAAGs had deliberately chosen against putting their energies into developing group work because they didn't think the practices were ready for it. In District 13, on the other hand, the MAAG concentrated from the start on district-wide audit because practices were not thought ready to audit on their own.

Generally, though, the variation in the amount of group work appeared to have more to do with differences in the MAAGs' abilities to obtain funds than their attitudes to joint work. Most of the larger projects were funded by top-sliced regional monies through a process of competitive tendering. This inevitably favoured those with greater experience of writing project proposals and was a cause of some considerable resentment:

> *"Some MAAGs have acted as wings of the College - certainly two in this region have very senior members of the College as chairs - so as a result they have concentrated on some very big glitzy projects which have got regional funding. The region sees them as the most effective MAAGs because they have got lots of money for projects - which I think is a very stupid way of measuring them. Who knows how well they are working with practices? We are almost bottom on the table of MAAGs. We only had one project funded by region, but so what! The only reason these others have swept the table is because they have already written audits ready to apply for funding the minute applications are invited and the region usually wants bids in by yesterday."(C14)*

*Interface audit between primary care and hospital and community services*

While the circular did not mention inter-practice audit, it did draw attention to the need for audit of services at the interface between primary care and other sectors of the health service. All the MAAGs were aware of this aspect of the circular and seven of them had at least one interface audit project going, usually with regional funding (which had favoured interface projects). For two of these groups - one that shared accommodation with the hospital audit committee (MAAG 1) and another with a longstanding local history of nationally funded interface projects (MAAG 3) - interface work was a major focus. Generally, however, interface was currently the least significant part of the study MAAGs' activities. It was widely assumed that the first priority was to get audit going among general practitioners and that that in itself was hard enough without the added problems which would come from seeking to work with hospitals.

There was also a common view that GPs would be less interested in audit that went beyond the practice. Yet, wherever they had been given the opportunity to express an opinion it was clear that this was not the case:

> *"The MAAG has taken the stand that they don't want to invest too much energy in this direction just yet. Their impression is that there is just too much going on with GPs in their practices to be able to stand back and look at the interface. But with hindsight gained from talking to GPs it would have been opportune to do something earlier - GPs have shown themselves to be concerned about their relationships with secondary care. In hindsight we could have run down the two tracks together."(S11)*

In District 10 where GPs had been surveyed to find out how they would like the MAAG to develop, 48% of respondents stated that they would like to be involved in primary/secondary care interface audit. This MAAG had tried, but so far failed, to act on this information. The chair's account summarises some of the problems that this and other MAAGs had encountered:

> *"It is time intensive - that is the issue. It is easy to do audit in the practice because we can all get together over coffee in a break, but trying to work with other groups entails lots of meetings to discuss. Also I get the feeling that audit in hospitals is a whole different philosophy. The consultants are auditing the juniors...junior bashing sessions, and I am not comfortable with that. We had a specialist in back pain in to talk - our hidden agenda was to see if we could do some system of fast tracking referrals for pain which we felt could be due to malignancies - we were wondering if there was some kind of protocol we could generate which would help here and which could be audited. This is sinking due to lack of enthusiasm at the moment - from both ends....[Q. Has the hospital ever approached you?] No. They haven't seen general practice as being useful in terms of telling them things they need to know. Also, what is interesting is that, since the provider/purchaser split came about we are not sure we want to be tied in with one provider unit. They may be aware that us doing joint audit with them may alert us to their inadequacies. Maybe that has something to do with their lack of interaction. But you could argue that it would be better if they did work with us and tried to show us their strengths."(C10)*

The interface projects that had been undertaken had met with variable success. In Districts 1 and 3 the sustained effort was felt to have led to a real change of atmosphere:

> *"The consultants didn't used to think the GPs listened to them and the GPs didn't think the consultants...at the first meeting we had they were all rowing at each other. Now it's totally different - every meeting we have there's a good smattering from both hospitals and everyone's on first name terms. If nothing else we've broken down this boundary between primary and secondary care."(S1)*

But these were exceptional cases. The more usual view was that interface work was an uphill struggle which involved starting again from scratch each time a new project was

initiated. Cross-representation with a hospital audit committee was recommended in the circular and existed in most of the study MAAGs but, like the MAAGs' educational links, this cross-representation appeared to be of limited value. Hospital audit committees often arranged their meetings at times when the GP representative could not attend and few hospital consultants participated regularly in their MAAGs. Those interface projects that did get off the ground depended rather on the presence of a MAAG member with a personal interest in a particular topic or, more often, on links established between lay support staff.

*Distribution of support*

The circular made it clear that the MAAG's job was to ensure that all practitioners and practices participated in audit, but it said nothing about how the MAAG should allocate its resources to bring this about. There was also no mention in the circular as to what should be done about practices that chose not to do audit. As mentioned in Chapter Three, the original intention as stated in the working paper on medical audit (Department of Health 1989) was that "once satisfactory arrangements to support audit are in place locally", GPs' terms of service would be amended to include a requirement to participate in medical audit. However this plan was resisted among those concerned with primary care audit at the Department of Health and the proposed amendment was never made. Thus MAAGs had no right or duty to compel practices to participate in audit and no sanctions to use against those that resisted persuasion.

Seven of the study MAAGs (1,2,6,8,9,13,14) had encountered practices that refused visits and did not want anything to do with the MAAG - the numbers ranging from "one or two" to estimates of 10-15%. A few of these practices were known to be auditing independently but others - dubbed by one MAAG the "refuseniks" - had apparently rejected audit on ideological grounds. In one of these districts (District 1) the MAAG was pursuing the non-cooperative practices with a letter from the chair which reiterated the professional responsibility of all general practitioners to participate in audit. However, respondents from the other six made it clear that the MAAG had neither the right nor the will to demand cooperation and would not be putting any pressure on the missing practices. Some of these respondents acknowledged that their MAAG had perhaps "taken no for an answer" rather easily in the first place:

*"Some of us have liked visiting practices and finding out what is going in and others have actually shied away from that idea. We haven't actually pushed ourselves. As regards going out there and insisting on meeting people, the members do not want to be evangelists. They want to be there to give advice, but not to go out and ask what audit is going on."(C9)*

Other MAAGs, in contrast, had clearly approached the visits from the start as a positive challenge. MAAG 10, for example, had organised an anticipatory role-playing session for members to rehearse the arguments they would use to get into resistant practices. MAAGs of this kind were much more likely to have achieved access to all practices.

In addition to the basic rounds of visiting which, in theory, covered all practices equally, all the MAAGs provided more focussed support to some practices in the form of additional help or extra visits from support staff or GP facilitators. The allocation of such support was determined by a combination of two contradictory principles. First, all the study MAAGs were committed to responding to demand, although there was widespread recognition that such a strategy was likely to lead to disproportionate amounts of MAAG effort going into practices which were already converted to audit because they were the ones most likely to make requests. In some districts it was clear that this had already happened, with support staff commenting that they were spending much of their time helping the more developed and sophisticated practices with bids for regional funds for audit projects. The common view, however, was that:

*"It's only fair to give help to anyone who asks for it - you can't discriminate against people just because they work in practices which are more clued up to audit."(S1)*

It was generally hoped that once practices reached a certain level of competence they would stop asking for assistance and therefore demand of this sort would be self-limiting. In fact, several of the MAAGs had already discovered this was not the case and three of them (1,5,6) were reluctantly taking steps to ration support to their most demanding practices. Others, however, were determined they would never do this.

The second criterion for giving extra help was that it should be concentrated on those with the most perceived need as assessed at the initial MAAG visits. This principle applied in all but a few of the smallest or exceptionally well resourced districts, where such targeting was not felt to be necessary because there was enough capacity to deal with everyone's requirements. In most places, therefore, follow-up was concentrated on the practices with least experience of audit and those having particular difficulties:

*"Our priority is always with the practices that haven't done any audit before. With those practices we really will help: Ring us - we'll be there. You've got problems - we'll listen, whether they're to do with the practice manager, your life being in ruins...whatever. That's really the priority over anything else, because they're the ones where it is worth putting the energy in."(S6)*

It was recognised, however, that not all non-auditing practices were equally interested in audit or wanted the MAAG's help. Six of the MAAGs (1,4,5,9,13,14) acknowledged that they had given up on the most uncooperative minority because they saw these practices as impossible to deal with and therefore a waste of time:

*"There are some practices which will never do audit, and I knew from other signals which these were before I walked in the door. They're the ones that couldn't care less. It's difficult to get over to them the strongly positive side of doing audit - telling you about yourself as a doctor. I think they're the ones that see the patient as the enemy." [Q. Do you feel you will make any inroads?] "I think it is beyond my skills."(F5)*

Many respondents, including some of the FHSA managers, expressed the view that audit was not the only thing such practices were not doing, that the FHSA would know who they were without help from the MAAG and that it should be left to "deal with them in other ways".

The overall effect of these combined approaches was that MAAG resources were concentrated on the middle tier of practices ranging from inexperienced but willing to competent and enthusiastic. At each extreme outside this range there was a small minority of practices that, at least in some places, did not receive much at attention at all.

## APPROACH TO AUDIT

In their work with practices, MAAGs had the job of explaining what audit was and how to do it. By the advice and feedback they gave to practices and the extent to which they supported or discouraged audit in particular areas or on particular topics MAAGs had considerable opportunities to influence how audit was perceived and undertaken in their districts. Some of the study MAAGs had written statements of intent about the type of audit they intended to promote, but few respondents could remember in detail what these said. Most talked rather in terms of an informal consensus within the MAAG regarding the messages to be conveyed to practices. The nature of these messages with respect to audit methodology and the areas in which audit should be undertaken are considered

below.

*Audit methodology*

The only comment about methodology in the circular was that MAAGs should encourage "regular and systematic" audit. In principle, the majority of the study MAAGs had interpreted this as meaning commitment to completing the audit cycle and encouraging practices to go through the process properly, for example by setting standards before investigating practice. A few MAAGs, in addition, had explicit objectives concerned with encouraging practices to make audit multi-disciplinary and to establish it as a routine part of practice. In practice, however, the image of audit being put across in most districts was much less rigorous than these expressions of intent implied and the need to complete the audit cycle was very much played down.

A number of different reasons were given for the discrepancy between policy and practice, some relating to the perceived needs of practices but others clearly linked to doubts about what the MAAG had a right to expect. Chief among the former was concern to start from where the practices were at and not to frighten them off by being too challenging. As one lay coordinator put it:

> *"We're not paranoid about which way you go round the cycle or where you start on it. The thing is, we're dealing with GPs from all different cultures and communities and their comprehension may be different. So you have to be flexible. You can't just go in with this complicated audit cycle and walk out and leave them baffled. We think more about the doctors really than the specifics of audit."(S1)*

In addition, some respondents were against putting too much emphasis on the "correct" audit process because they felt it was inappropriate to general practice culture:

> *"To go right through the audit process is an act of extremely slow discipline for a GP who wants to think quicker. Doctors tend to act fast on inklings. We may well find the process changes a bit in general practice. I suspect this is what will happen - little bits will be left out."(C11)*

As far as expectations were concerned, most MAAG respondents had quite limited views of what they could reasonably ask practices to undertake in the way of audit, and they were therefore inclined to be grateful for, rather than critical of, anything that was produced. As one chair put it:

> *"I am after ensuring that audit gets established and to assist on completion of the*

*audit cycle. I would like to see GPs auditing their own standards. But we are always so pleased when they produce anything - anything at all. Audit is an awful subject - you always fail, so it is a big success to get GPs concerned enough to start looking at the quality of their care."(C2)*

This view was particularly prevalent in those MAAGs that saw themselves as ordinary, non-expert groups and whose members were often acutely aware of their own limitations in relation to audit. As the coordinator in MAAG 11 commented:

*"I, personally, think it would be helpful to have some agreed minimum standards of audit, but I would not get agreement or support from the members for this. I would say that there is no point in doing audit unless they are willing to change if necessary. But, to be honest, the MAAG thinks it's OK as long as practices aren't doing audit* ***wrong****. I don't think the MAAG has got to the level where it feels it can judge others. It seems too critical to be criticising GP's audits when the members themselves don't have it right."(S11)*

Generally, the more MAAGs empathised with their fellow practitioners, the less they felt it was appropriate to expect:

*"We certainly will not be telling GPs they ought to be changing as a result of any audit they do, because it depends on the extent to which it is a priority for them in the context of other demands."(C10)*

In contrast, the more academic MAAGs - those with university or RCGP connections and more personal experience of audit - appeared to feel much happier with their pedagogic role and were often more demanding of their practices. As the chair of MAAG 12 said:

*"We are quite adamant that people must understand that audit is cyclical."(C12)*

This chair was determined to avoid what he saw as the "slipshod" and "homespun" approach of other MAAGs and had decided instead that the best way to convey the principles of "proper" audit was to encourage all practices to participate in a single centrally organised exemplar project rather than work with them on an individual basis. But this approach was very much the exception. In most districts it appeared that practices were receiving relatively little explicit advice about what audit should consist of or constructive criticism of their efforts.

### *Types of audit*

The 1990 policy on audit was a policy for medical practitioners and the task of the MAAG as defined in the circular was specifically to promote **medical** audit. No mention was made of clinical or organisational audit and audit of contractual obligations was

explicitly excluded. In practice, however, the distinction between medical and clinical or organisational audit is hard to sustain in primary care where the division of labour is often less rigid than in hospital settings and GPs are not only clinicians but also managers responsible for the finance, organisation and staffing of their practices. Perhaps because of this, none of the study MAAGs adopted a tight definition of medical audit in their work with practices and few of them appeared to perceive a clear distinction between clinical and organisational audit or to have any preference for either.

The pervading view was rather that audit should be defined as broadly as possible. As one chair commented:

> *"If it moves - audit it, as long as you can see some clear benefit to patient care. There really isn't an area of practice where you cannot slightly change the emphasis and change it into audit."(C4)*

In some cases the notion of "benefits to patients" was also interpreted quite widely, so that, for example, auditing the time it took for the FHSA to respond to GPs' letters about contractual issues was regarded as quite acceptable by one MAAG. The boundary of appropriate audit, insofar as such a thing was seen to exist, tended to be drawn rather between audit which the MAAG thought was meaningful to general practice (however this was defined) and audit of practice activities relating to FHSA targets and health promotion clinics which some MAAGs rejected on principle. Several respondents stated that their MAAG was not prepared to support practices engaging in this kind of "service audit" because they saw the whole enterprise as misconceived:

> *"You want to look for sustained change that affects clinical practice and that the morbidity and mortality of the things you look at actually improve. That is precisely why service activity is such a useless thing to be auditing and precisely why our MAAG has decided it does not want anything to do with it. It is nothing to do with raising standards of care for patients - necessarily. [When you say service audit...?] "I mean how many smears or immunisations you do, or if you prescribe too much of this or that antibiotic. Those have knock on effects on patient care, but directly they are nothing to do with patient care."(C14)*

This MAAG and a couple of others had extended their exclusion criteria to include audit of anything explicitly concerned with the *Health of the Nation* targets because they were regarded as a misguided waste of time.

But not all MAAGs felt like this. Some respondents were quite happy to support audit in the areas mentioned above if this was what practices wanted, because their primary concern was to respond to demand. Others did so on more pragmatic grounds, arguing

that, when it came down to it:

> *"Helping people with standardising their health promotion clinics, whatever you think of the policy, is as good a way as any of teaching GPs to do audit."(F10)*

*Topics for audit*

As mentioned earlier, the circular encouraged MAAGs to develop audit of services involving shared care with hospital or community services and some of the study MAAGs had begun to do so. MAAGs were also enjoined to take account of patients' views and their satisfaction with services. One MAAG (15) had appointed a lay member of the MAAG and at her instigation had developed a questionnaire for local GPs to use to look at patients' perceptions. None of the rest, however had developed any systematic means of involving patients and few MAAG respondents (none of them GPs) expressed any interest in doing so. Apart from these issues, the circular contained no indication as to what topics should be subject to audit.

For the great majority of the study MAAGs much the most important criteria for acceptable and productive audit were that it should be "owned" by the practice and the topic should be voluntarily chosen. In order to achieve this, there was widespread commitment to being as non-directive as possible. All but one of the MAAGs deliberately avoided making unsolicited suggestions to practices about what they might audit, and most of them were committed to refusing advice on topics even when practices asked for help. The minority who were prepared to respond to such requests (MAAGs 4,6,7,9,10 and 11) included three MAAGs with strongly practitioner orientated MAAG chairs and three with lay support staff holding similar views. In these districts lists of possible topics were available on request, but they only included projects that other local practices had already undertaken. Thus these MAAGs could still claim not to be imposing their own agendas on the practices.

The one exception to the non-directive approach was MAAG 12 where the chair's commitment to using an exemplar audit overrode any concerns he might have had about diminished ownership of the audit for those involved. He was, nevertheless, concerned to point out that the topic of the exemplar (prescribing of vitamin B12) was chosen on educational rather than any other grounds:

*"We have chosen this subject, not because we are necessarily interested in it, but because it will not over tax doctors because B12 prescribing is not that common. At the same time it does illustrate all the aspects of audit well. It also needs the cooperation of all members of the practice and so illustrates the importance of team work."(C12)*

Despite their determination not to make direct suggestions to individual practices within the visits, all the MAAGs were offering ideas in other ways by, for example, publishing selected audits done by local practices in their newsletters, inviting presentations at study days and making sample protocols available. All these activities, however, were regarded as acceptably non-directive, because it remained for practices to decide what use they made of such information and opportunities.

As mentioned earlier, most of the MAAGs were also offering practices the opportunity to participate in joint audits on predetermined topics. Interestingly, even those groups which, at the individual practice level, were most insistent on the necessity of practices "owning" their audit topics and most wary of removing this ownership by providing funding or doing the work for them, appeared quite happy to ignore these principles when it came to larger scale funded audit projects. Some sought to justify this different approach on the grounds that the large projects were more akin to research, others argued that the topics were particularly important or that practices needed "something different to do" to maintain their interest. It seemed likely, however, that for many respondents the fact that such audit came with funds attached was the chief reason for the difference of attitude.

## MONITORING AND ACCOUNTABILITY

The circular required each MAAG to keep records of the problems it identified and the actions taken to remedy unsatisfactory situations. The MAAG was also required to undertake some evaluation of the audit exercise itself and to provide the FHSA with a regular report on the general results of the audit programme. Each FHSA was, in turn, held accountable to region for the proper operation of its medical audit system. The FHSA was expected to have sufficient information to be satisfied about the audit policy followed in its district and the general manager was expected to agree the programme and scale of medical audit activity with the MAAG chair. However, given that audit was to

be professionally led, it was not clear what input, if any, the FHSA should expect to have into MAAG policy. The study MAAGs' activities in terms of monitoring progress and reporting to the FHSA and the extent to which they took account of FHSA interests are discussed below.

*Monitoring progress*

The circular contained no details as to what type of information should be collected about progress with audit. It did emphasise, however, that the MAAG had a responsibility to protect the confidentiality of individual patients and doctors. The issue of confidentiality was taken very seriously by all the study MAAGs and one common strategy they developed to reassure and protect practices was to allow them to decide what information about their audit results, if any, to disclose to the MAAG. This policy, along with other measures such as lockable MAAG offices and exclusion of FHSA members and observers from sensitive parts of MAAG meetings, was widely felt to have prevented the risk of inappropriate disclosure of information. However, it left MAAGs with the problem that they had no systematic access to data which would enable them to assess or demonstrate the impact of audit undertaken by the practices. Likewise they had no way of knowing what problems had been revealed by audit or what any particular practice had chosen to do about such problems unless the practice chose to tell them directly.

In the absence of information on outcomes, attempts to monitor progress focussed almost entirely on measuring audit activity. In most of the study districts this got off to a slow start and was undertaken with varying degrees of enthusiasm and thoroughness. Almost everywhere, the initial practice visits were loosely structured and little useful information was collected. Realising this, and aware of the potential need to justify their existence, most MAAGs had set out on a second round of visits with the intention of obtaining a more systematic idea of what the practices were doing in relation to audit and a baseline against which they could measure progress. A few MAAGs baulked at the prospect of setting themselves up in judgment on their peers, and for some (MAAGs 2,9 and 13) this appeared to have been a major reason why they had given up systematic visiting:

> *"We had not suddenly become any more lazy than usual, nor were we any more than usually sceptical about audit. The problem seemed to be that, despite the courteous welcome, we felt as though we were intruding in our colleagues' practices. In particular we were uncomfortable with our role as assessors as this*

*role has become more explicit. We questioned our legitimacy in putting ourselves forward as capable of judging the efforts of our peers."(C2).*

In these districts, the only information held by the MAAG at the time of interview about local audit activities was that which had been volunteered by practices. The majority of MAAGs, however, had by then made more organised attempts to find out what was going on.

The major focus was on measuring practice progress round the audit cycle, with 12 of the 15 MAAGs seeking to do this in one way or another (see Table 8.2). In addition, six MAAGs were keeping records of the topics being audited and a few were trying to keep tabs on who in the practices was actually involved in the audit. None of the study MAAGs had attempted to collect any systematic information about the nature or extent of the changes in practice brought about as a result of audit or its impact on patient care, though a few had collected some examples of this on an ad hoc basis. Data collection ranged in complexity from a simple question "Do you do audit - yes or no?" to a sophisticated pro forma requiring information on multiple aspects of audit activity including frequency, regularity and completeness of audit.

In 1991, the Oxford MAAG had published an article on monitoring audit in the British Medical Journal which involved categorising practice activity into: No audit; planned audit; potential audit; partial audit and full audit (Derry et al 1991) and by 1993 the "Oxford" system had been adopted or adapted for use by 41% of other MAAGs (Lawrence et al 1994). Six of the MAAGs in the present study were using their own versions of the "Oxford model" and several others had developed similar approaches.

In addition to the variation in the extent of information sought from practices, there were major differences between MAAGs in the means used to obtain it. A few of the MAAGs used a rigorous approach of asking for written evidence, making their assessment and then checking back with practices that their records were correct. In most places, however, the approach was much more casual. Either assessments were based entirely on MAAG visitors' impressions of what practices were doing or on GPs' verbal reports of what they had achieved. In many districts it appeared that the practices themselves had not been given any details of the monitoring system that was being used. The rationale given for maintaining such a low key approach, especially by MAAGs where members

**Table 8.2: Information collected by study MAAG, requested by managers and/or included in annual report**

| Study district | Audit cycle | | Audit topics | | Beneficial change | |
|---|---|---|---|---|---|---|
| | Col | Req | Col | Req | Col | Req |
| 1 | * | * | * | - | - | * |
| 2 | * | (-) | - | * | - | * |
| 3 | * | - | - | - | - | - |
| 4 | * | * | - | - | - | * |
| 5 | * | * | - | * | - | - |
| 6 | * | * | - | - | - | * |
| 7 | * | (*) | * | (-) | - | - |
| 8 | - | - | * | - | - | - |
| 9 | - | * | - | * | - | - |
| 10 | * | (*) | * | (*) | - | - |
| 11 | * | (*) | * | (-) | - | * |
| 12 | - | - | - | - | - | - |
| 13 | - | * | - | - | - | - |
| 14 | * | * | - | - | - | - |
| 15 | * | - | * | (-) | - | - |
| TOTAL | | | | | | |
| Collected | 12/15 | | 6/15 | | 1/15 | |
| Requested | 10/15 | | 4/15 | | 5/15 | |
| Provided | 4/15 | | 4/15 | | 0/15 | |

KEY: Col* = information collected by MAAG
Req* = information requested by FHSA
◯ = information included in MAAG annual report (1991/92)

did the majority of the visits, was that it was important that practices should not feel threatened or mistrusted. Both GP facilitators and lay support staff were much less concerned about this potential danger and their methods of data collection appeared generally more robust.

Most respondents were well aware of the flaws in their approaches to monitoring and there was widespread scepticism about the reliability, validity and completeness of the resulting information. While some MAAGs were trying hard to improve their systems, keep their information up to date and check it against other sources such as practice reports to the FHSA, others were surprisingly sanguine about the lack of accuracy, perhaps because of their underlying cynicism about the whole monitoring exercise, whose main purpose was seen as satisfying the FHSA.

For many MAAG respondents evidence of increased audit activity - even if accurate - was regarded as a poor indicator of what was really being achieved. It was not so much what practices did as how they felt about it that really mattered and this was not measurable in quantitative terms. The real evidence of progress lay rather, they felt, in the changes in atmosphere and attitudes towards audit which they saw occurring in their districts. When asked what difference the MAAG had made, the response was often to cite examples of this sort:

> *"One of our facilitators is putting on an evening meeting next week. He's got 19 practices in his patch, and 16 are coming. We think that's pretty impressive. We've had to close the list now - the room isn't big enough! Two years ago you never would have got that!"(F7)*

However, they did not believe that such "soft" and anecdotal evidence would be acceptable to the FHSA as evidence that the MAAG was doing its job. It was necessary, therefore, to provide the figures which would "feed the beast". As long as these showed movement in the right direction, it did not matter whether they were more or less correct.

Ironically, it seems that in this perception the MAAGs were only partly right. While most FHSA managers were initially keen on receiving such activity data, some were as dubious as the MAAG respondents about what it really signified:

> *"I'm not one for percentage indicators. I think a lot of people are saying there's a lot of doctors signed up, but if you went and looked at what they're actually doing and what it means, it's really next to nothing."(G1)*

What such managers increasingly wanted instead was hard evidence about outcomes which would demonstrate value for money.

*Reporting to the FHSA*

The requirement for a "regular report" to the FHSA was universally interpreted by the study MAAGs as meaning an annual report, and all had produced one for the year 1991/92. These varied in length and substance from a couple of sides of A4 to an impressive and glossily produced book. Information provided included any or all of the following: A statement of objectives, accounts of the MAAG's activities and projects funded, an estimate of the number and topics of audits undertaken and plans for the coming year.

Table 8.2 shows the type of information collected by the each of the study MAAGs, the categories of information that they had been asked by their FHSAs to provide and what was included in their annual reports. As may be seen, by the time of interview the majority of the FHSA managers had asked for information of one sort or another about their MAAG's activities. The four that had held off asking included one (G3) who felt himself to be too new in post to begin probing such a sensitive area, one (G8) where the MAAG had been delayed in starting because of problems with funding and who therefore felt it needed to be given extra time to get going, and the two managers (G12 and G15) most firmly committed to leaving the MAAG in the hands of the medical profession.

The main reasons managers gave for wanting information were to assuage their own doubts about the MAAG's worth or to justify the costs of the MAAG to the FHSA board. In theory, managers were themselves accountable to region for the effectiveness of their local audit arrangements, but none of those interviewed had ever been asked anything about what their MAAGs were doing. A minority of managers had also asked their MAAGs for more detailed information about individual practices, particularly those known not to be auditing, with the aim of identifying particular problems or resource needs. However, as mentioned earlier, requests from the FHSA about specific practices were regarded by all the MAAG chairs as quite improper, both because they contravened the MAAG's commitment to confidentiality and because the motives of managers who made such requests were regarded as questionable, and all such enquiries had been firmly

rebuffed.

As the table shows, the amount of information provided to the FHSA about the "general results" of the audit programme was somewhat less than that collected and considerably less than what was required. Only five of the first year reports included any data on progress round the cycle or audit topics and only three provided information which FHSA respondents said they actually wanted. The behaviour of individual MAAGs in this respect depended in part on their attitude to the FHSA. Some groups, such as MAAG 7, regarded a positive relationship with the FHSA as an essential prerequisite to helping practices and patients obtain whatever benefits might be available from audit and were committed to anticipating and considering how they might accommodate their general manager's needs:

> *"The whole MAAG felt that it was very important that we should start to meet the general manager more regularly. We've invited him to the next meeting to tell us what he expects of us. We've already decided to be more proactive in sharing information." (S7)*

At the other extreme, there were a few MAAG respondents who claimed to be impervious to FHSA criticism because they were relatively indifferent about the survival of the MAAG on anything other than their own terms. This was the view of the chair of MAAG 11, for example:

> *"None of us in this MAAG are that committed to audit that we would fight for the existence of our MAAG. I think they need to know this at the FHSA and I have told them so. We just have to do our job and they have to pick up what they can out of it. I think it is important to say that our lives won't collapse if the MAAG disappears."(C11)*

The majority, however, recognised that they had some responsibility to account for the resources they received and most of them planned to include more information on activity and topics in their next reports.

In addition, there was a general awareness of the increasing need for evidence about audit results but, given the difficulties of collecting systematic data in this area and the problems of knowing what it really meant, most MAAG respondents were uncertain as to how to provide what was required:

> *"We've been asked for examples of outcomes. I was trying to get from them what sort of outcomes were meant. We've had audit seminars for practice staff, and everything we do we do an evaluation form on. We've got outcomes in terms of that sort of feedback. Did they want that or the sort of outcomes about changes*

*in patient health? That sort of outcomes I don't think we can produce. We can wrack our brains and unofficially I can think of some examples of beneficial change. But it doesn't necessarily happen in an audit cycle way - they haven't necessarily finished the audit when they make the change."(S6)*

***Co-ordination of strategy with the FHSA***

As mentioned in the previous chapter, most of the general managers interviewed foresaw a time when they would expect to have some input into the MAAGs' audit agenda through negotiation over the annual business plan and had made this clear to the MAAG chair. At the time of interview, however, only a handful of the most bullish managers had made direct requests for work to be carried out. These included requests by the manager of District 7 for audits of minor surgery and prescribing and by the manager of District 2 for the MAAG to comment on a proposed protocol for diabetes management. Both managers had backed off quickly in the face of the angry responses they received, but planned to revisit these issues in the future.

In the other direction, one MAAG (MAAG 10) had asked the FHSA what topics it would like audited and was proposing to suggest these to any practices who asked for help. This MAAG's willingness to take such a step was a reflection of local confidence that the general manager would not make any inappropriate demands. But this was an exceptional case. For the great majority of the study MAAGs the strength of their commitment to being non-directive made them chary about making any suggestions, let alone proffering ideas that were seen to come from the FHSA. Even the groups most sympathetic to service views saw collaboration as something for the future rather than the present.

The one way in which several of the MAAGs were already beginning to collaborate with their FHSAs was by providing assistance and expertise in relation to other quality initiatives such as FHSA total quality management projects and developments involving the Patient's Charter. This was especially the case where MAAG staff were based in the FHSA. In some places opportunities for such cooperation were openly embraced by the MAAG as an appropriate sharing of skills and an acceptable means of building good will with the FHSA. Elsewhere, however, there were more doubts about propriety. The lay co-ordinator in District 13, for example, who was participating in joint work with the FHSA on cholesterol screening which had been arranged through the medical adviser, felt

"extremely guilty" about her involvement, even though she believed that, as an individual, she had the appropriate skills.

## Chapter Nine

# RESPONDENTS' VIEWS

This chapter contains an assessment of the MAAG initiative from the point of view of those involved. It includes discussion of respondents' perceptions of the achievements and shortcomings of their own MAAGs, their attitudes to the policy on audit as a whole and to the provisions contained within the MAAG circular and their views about how MAAGs might develop in the future.

## *Attitudes to the study MAAGs*

### *Achievements and shortcomings*

All respondents were asked what, if anything, they felt their MAAG had achieved so far and in which respects it had been unsuccessful. The wide range of achievements and shortcomings mentioned by respondents is summarised in Table 9.1. There are several interesting features both about what appears on and what is absent from this list.

First, in relation to audit, the achievements respondents chose to mention related almost entirely to building up an appropriate infrastructure for audit in terms of skills and resources, negotiating a receptive environment through establishing trust, and developing understanding of the relevance of audit and the potential breadth of its application. Interest, and often pride, in these nonspecific and usually unquantified developments reflected the widespread belief that it was more important, at least in the beginning, for the MAAG to engender a sound culture for audit than to rush to meet numerical targets for audit activity. Notably, hardly any of the respondents chose to cite a quantitative increase in audit activity as an achievement even though this was what the MAAGs had been charged to bring about and almost everyone believed that such an increase had actually taken place. (This belief was held with confidence, despite the scepticism mentioned in the previous chapter about the quality of the data collected in this area and, in some districts, a lack of any systematic evidence at all.) Similarly, nobody stressed the MAAG's success in getting practices to complete the audit cycle, but this is perhaps less surprising given that few respondents felt the MAAG had got very far in this respect and evidence of audit outcomes was in conspicuously short supply.

**Table 9.1 Respondents' perceptions of their MAAGs' achievements and shortcomings**

| |
|---|
| *Achievements* |
| *Audit* |
| Getting doctors to think about the quality of the care they give |
| Raising the profile of audit |
| Diminishing fear and increasing acceptance of audit |
| Producing guidelines |
| Enhancing audit skills |
| Extending the range of topics looked at through audit |
| Extending the range of primary care staff involved in audit |
| *Professional development* |
| Getting into isolated practices and providing professional support and advice |
| Getting doctors talking together and forging good relations between clinicians |
| Developing skills of those involved with the MAAG |
| *Service development* |
| Assisting practices to obtain resources |
| Assisting practices to meet FHSA requirements |
| Assisting practices to develop their infrastructure |
| Drawing attention to variation in standards |
| Developing a collective view of local needs |
| *Shortcomings* |
| Failing to engender good quality audit |
| Failing to demonstrate beneficial change |
| Failing to get cooperation from all practices |
| Being over-concerned about confidentiality |
| Being over-cautious in approach to practices |
| Lack of relevance of approach to practice audit needs |
| Lack of relevance of approach to FHSA audit needs |

The other significant feature of the table is the wide range of achievements mentioned that had little directly to do with audit but derived, rather, from the wider developmental opportunities which the creation of the MAAG as an organisation had given rise to. Thus emphasis was placed on ways in which the MAAG's resources, activities, skills and connections were improving the quality of primary care directly through enhancing communication, increasing integration and generally facilitating practice development. Many respondents both from MAAG and FHSA regarded this as an important aspect of the MAAG's work. For some people, especially those who were relatively sceptical about the value of audit or its likely impact on patient care, the spin-off benefits of the MAAG's existence were in fact its central achievements.

In contrast to the wide-ranging spectrum of achievements, the shortcomings mentioned by respondents relate much more consistently to the MAAG's function in promoting audit. Specifically, the emphasis was on the MAAG's failure to progress to the point where effective and relevant audit could be shown to be taking place. For some respondents, progress in this direction was regarded simply as a matter of time, commitment and choosing the right strategy. For others, it was much more of an open question whether success in the initial process of getting audit established was an adequate basis for optimism about the MAAG's capacity to bring about effective and relevant audit in the longer term. As might be expected, respondents who were doubtful about the MAAG's future impact were more cautious about celebrating its achievements to date than those who felt confident about continued progress.

*The value of the MAAG*

Table 9.2 shows the distribution by district of respondents' views on the value of their MAAGs. These are not graded responses to a specific question about the overall worth of what was going on - no such global question was asked. The categorisation of respondents' views has been done rather by taking account of all evaluative comments made by each person (either voluntarily or in response to the researcher's questions) regarding any aspect of their MAAG's activities at any point during their interview. Thus the category *positive assessment* includes all respondents who made positive but no negative comments; *mixed assessment* includes all those who made both positive and negative comments; *negative assessment* includes all respondents who made negative but no positive comments; and *unsure* includes everyone who made neither positive nor

**Table 9.2: Respondents' views of the value of their MAAG**

| Study MAAG | Positive assessment | Mixed assessment | Negative assessment | Unsure/ judgment reserved |
|---|---|---|---|---|
| 1 | | S,C,G | M | |
| 2 | | S,C | G,M | |
| 3 | | S,C,G,M | | M |
| 4 | G,C | M | | F |
| 5 | | F,C,G,M | | |
| 6 | | C,G | | S |
| 7 | | S,G,M | | C |
| 8 | G | S,C | | |
| 9 | | | G,M | G,S,C |
| 10 | | F,C,G | M | |
| 11 | | S,S,S,C | S,M,G | |
| 12 | G,C | S,S,M | | G |
| 13 | | C,G,S | M | |
| 14 | | F,C | M,M | G |
| 15 | G,C | S | | |

G = general manager; M = medical adviser; C = MAAG chair; F = GP facilitator; S = lay support staff

Underlined initials denote respondents who held a "service" view of audit (see text)

negative comments and/or said it was too early to make any judgment about the MAAG.

Clearly this is a very rough measure. Given the wide variety of personal and situational factors such as occupational status, personality, knowledge of the MAAG, length of and course taken by the interview, which are all likely to have affected respondents' willingness and opportunities to express their views, what they actually said is, at best, an imperfect indicator of what they actually thought. In addition, the intensity of the views held by respondents was very variable and the range of issues about which comments were made was very wide. In the "mixed assessment" category, the balance of positive and negative views varies substantially.

Nevertheless, there is some limited evidence of a correlation between categorisation by this means and other more direct methods of measuring attitudes to the MAAG. This evidence comes from comparison with findings concerning manager satisfaction with the MAAG from the national postal questionnaire survey of MAAGs and FHSAs carried out in 1994 (Humphrey and Berrow 1995). In this later study all FHSA general managers were asked how satisfied they were with four different aspects of the MAAG's work. The findings showed that 27% were "not satisfied" in at least one respect. Fourteen of the managers who participated in the present evaluation also responded to the later survey. Ten of these were categorised in the present study as holding positive or mixed views about their MAAGs, four were non-committal or expressed only negative remarks. The ten who were wholly or partially positive about their MAAGs during the earlier interviews were all "satisfied" or "satisfied with reservations" with all aspects of the MAAG in 1994. In contrast, three of the four who said nothing positive in the earlier study subsequently described themselves as "not satisfied" with the MAAG in at least one respect. It must be accepted, however, that these numbers are very small.

While acknowledging the methodological limitations of the categorisation, it is interesting to consider what the distribution of responses appears to show about respondents' attitudes to their MAAGs. First, two thirds of the respondents (44/65) made some positive remarks about what their MAAGs were doing, but very few were unequivocally complimentary. This last minority included none of the support staff or facilitators who, as a rule, spent more time working for the MAAG and might be assumed to have better knowledge of its impact on practices. Second, respondents' attitudes to the MAAG were

closely linked to their views of audit as described in Chapter Seven. Of the 18 respondents who were uncompromisingly committed to the "service" view of audit (see underlining on Table 9.2), only three had anything positive to say about their MAAGs. Moreover, the "negative assessment" category is peopled exclusively by respondents from this group. In contrast, all but six of the 47 respondents who were committed either wholly or in part to a "professional" or "practitioner" view of audit made at least some positive comments.

It is tempting to explore the relationship between respondents' views about the value of their MAAG and other features of the MAAG or district. However, given the narrow focus of the indicators of district character available (such as MAAG finance, membership, office location or district demography) and the wideranging concerns that lie behind respondents' assessments it is not suprising that a straight comparison of the two types of measure reveals no identifiable patterns. The one exception relates to the circumstances surrounding the setting up of the MAAG which were discussed in Chapter Six. Comparison between the views of respondents from the eight districts where a consensual approach had been taken to setting up the MAAG and those of people in places where an oppositional approach was adopted shows that the former were significantly more likely than the latter to make positive comments about their MAAGs ($X^2_1 = 4.10$; $p=0.04$). However, while this is an interesting association which appears to make some sense, the uncertainty surrounding the measures involved requires it to be regarded with caution.

### *Perceptions of the policy for audit in primary care*

The main focus of investigation in the present study was on the activities and development of the study MAAGs. Nevertheless, during the course of most interviews a fair amount of information was also collected on respondents' more general views about the 1989 policy on audit and the strengths and weaknesses of the MAAG circular. What people thought about the policy as a whole is considered here separately from their feelings about their own MAAGs, but attitudes were obviously coloured by local experience. Views about the policy are discussed in terms of the focus on audit, the

conditions under which audit was to be carried out in general practice (its non-contractual status and the lack of financial incentives) and the arrangements for MAAGs (structure, funding and specification of task).

*The focus on audit*

As discussed in Chapter Seven, the great majority of respondents regarded audit as a worthwhile activity in principle, though they differed in their views as to the nature of its benefits. Confidence in the likelihood of being able to establish effective audit on a wide scale in primary care varied greatly, but very few respondents doubted that this was a task worth attempting. The exceptions were two MAAG chairs (C6 and C7) who were concerned about the limited evidence that audit is effective and a few of the support staff and GP facilitators, whose contact with practices had led them to question the relevance of audit to the problems they saw:

> *"The MAAG, I feel, has been quite successful in being fairly useful to some practices we've worked in. But a lot of our work, you're getting audit being done and you're not necessarily seeing it changing things. Whether audit is the way to improve primary health care, I wouldn't like to say." [Q. What do you think?] "It's very different from other parts of the NHS. You're working on the basis that it's GP led - professional autonomy etc. You can go to a practice and see all sorts of problems and that's irrelevant if they want to audit the care of their epileptics or something." [Do you find it frustrating?] "Not as such, because I don't feel obliged to save the world. But I must admit that a lot of money's gone into audit and I wonder whether it's the best way of spending that money. Those that are really in a dire way, they don't have time for audit."(S6)*

In addition there were some MAAG chairs who believed in audit themselves, but were sceptical about the government's own commitment to it and suspicious that the audit programme was really just a convenient softening up process to facilitate the transformation to managed general practice:

> *"In my most cynical moments I think the MAAG is just supposed to go round acting as a buffer between a time when everything was voluntary and a time when it will all be obligatory."(C9)*

These exceptions apart, the majority of respondents both accepted the promotion of audit as an appropriate policy objective and appeared to believe that the government's interest in this area was benign.

There were, however, major differences of opinion as to how far it was appropriate to single audit out for such special treatment. Some respondents, particularly those most committed to the professional view of audit, regarded audit's pre-eminent position in

policy as entirely appropriate, believing it to have a unique educational role for clinicians that could only be diluted or compromised by integration with other quality assurance or service development activities. Others, by contrast, saw the narrow focus on audit as an arbitrary and unnecessary constraint on the potential for an organisation like the MAAG to work towards quality improvement at a wider level.

*Conditions for audit in general practice*

**Non-contractual status**

There was general agreement that if audit had been included in the GP contract widespread participation would have been achieved more quickly and coverage would have been more comprehensive. Despite this, only four respondents in the entire sample (all general managers (2,9,13,14)) thought that audit should have become a contractual obligation for GPs.

A combination of practical and idealistic arguments were put forward to defend the voluntary status of audit. It was suggested that, since the benefits of audit depend upon the personal commitment of the participants (to self-examination, to learning from the experience and to making changes), compulsory audit undertaken in the absence of such commitment simply would not work. Since audit can be done "at a superficial brainstem level", it is possible to pay lip service to it and actually get no benefit from it. Since GPs would have no compunction about cheating, contractual audit would be impossible to police:

> *"It would make it much more easy - then we could just give them the trash they want. A MAAG would not be needed - you would just fill out a form. It might not bear any relationship to what we are actually doing but, in line with other GPs, I would just find a way of massaging the results and provide the FHSA with what they want."(C2)*

The general view, even among those who were most frustrated by the constraints of depending on persuasion to bring practices on board, was that the rewards of this approach would be higher in the end:

> *"The future of primary care is in preserving the entrepreneurial bit and carrying the GPs with you. If you do it the other way then you get a salaried service and a "job's worth" mentality, for example sticking to 9 to 5. This would be our loss. When you get into the business of obligations you get minimum standards. Audit at the moment I see as an opportunity to get away from these into higher ones."(M12)*

However, the four managers who disagreed with the principle of voluntary audit rejected all such arguments as special pleading. Their view was that if audit had been put in the 1990 contract in the first place, it could have been "bulldozed through" along with everything else:

> *"There would have been the initial backlash to deal with, but then they would have delivered."(G14)*

**Financial incentives**

As discussed in Chapter Eight, despite the absence of any suggestion in the circular that practitioners should be paid to do audit, the majority of the study MAAGs had developed ways of offering some financial reward. Among respondents as a whole, few but the educational purists believed that it was either practical or necessary to expect GPs to do audit without additional resources. Nevertheless the ad hoc approach taken by most MAAGs of handing out small sums of money for individual projects - often begged off other FHSA budgets - was seen as far from ideal. Rather there was widespread agreement that if the government really wanted audit undertaken it should have been prepared to pay for it. Interestingly, some respondents appeared to feel that if audit were adequately remunerated the problems associated with making it contractual would no longer apply.

Direct payment apart, most respondents recognised that audit would effectively become linked to funding in the future, because qualification for payment for health promotion activities under the new banding system would depend on having information about patient care that could only be obtained through audit. But this was not seen as payment for audit, rather it was a way of ensuring that those who did not do audit would not get paid. Concern about these developments was surprisingly muted, given that they were also regarded by many as a way of bringing audit into the contract through the back door. The reason appears to be that a real distinction of principle was perceived between linking audit to activities which practitioners could choose not to participate in (even though their practice finances might suffer as a consequence) and obligatory audit about which they would have no choice at all.

*Attitudes to the MAAG circular*

Not surprisingly, respondents who were happy with their own MAAG tended to be reasonably satisfied with the provisions in the circular, whereas those who were

dissatisfied with what was happening locally were more likely to find fault with the general arrangements. But, just as very few people objected to the principle of a policy for audit, hardly anyone was against the idea of a MAAG in some form. The one exception was the medical adviser in District 13 who "resented very much" the need to adhere to the proposals in the circular:

> *"If we had been given a budget and a brief to get audit going but were not told how to do it then far more creative things would have happened I'm sure. As it is it's easy for the FHSA to tick, tick, tick and say "There, we've done what is required." and yet this may not mean very much at all."(M13)*

However, this respondent also stood out from all the rest for the vehemence of his feelings about the damaging impact of his MAAG on local practices.

**Structure**

As discussed in Chapter Six, all the study MAAGs were fairly similar in terms of size and categories of representation, but in character and outlook they varied substantially. While some respondents were very pleased with the mix of individuals involved in their local MAAG, others regarded the membership as seriously dysfunctional. But it was generally agreed that success or failure in this respect had little to do with the nomination process specified in the circular. Rather, getting a good group was seen as a matter of luck (and, in some cases, good judgment) and several respondents expressed concern about the large element of chance involved.

With regard to the groups represented on the MAAG, there was little criticism from any of the MAAG GP respondents about the membership categories recommended in the circular or the numerical preponderance of GPs, but other respondents repeatedly commented on the problems of such a GP-focussed group. The dominance of the medical perspective and inadequate representation of the views of other primary care team members was seen by both MAAG staff and FHSA respondents as limiting the effectiveness of MAAGs' work with practices and inhibiting the shift towards genuinely multi-disciplinary clinical audit. In addition, concerns were expressed about GPs' lack of appropriate organisational and group working skills and the failure of the circular to anticipate these shortfalls. As one medical adviser commented:

> *"Individuals should be trained up to their roles. But, because of the general culture that GPs do not need added training because they are continually educating themselves or are already sufficiently trained, the members are not adequately trained for the tasks before them. In this culture it is likely that success*

*or failure will depend on individual talent and the direction of the MAAG is seriously vulnerable to the individual idiosyncracies of members."(M1)*

Among the study MAAGs, staff were often working hard to ensure that the group developed explicit and realistic objectives, that individual members had properly defined roles and that meetings led to decisions being made. But in some places this appeared to have caused considerable resentment among MAAG members, as the following description shows:

> *"Attending my first MAAG meeting I was horrified - it was just two hours of nothing. I had been round to each member to ask them what the MAAG should be doing and they had not given it any thought. Mainly the response was that they could not understand why I was asking them and that I should be out doing audit. That was as far as it went. So at the next meeting I said that it seemed like everyone has different views and I thought it would be helpful if we wrote down where the MAAG is now and then talked about where it should be in the future. But I really misjudged it - this really threatened them and they all walked out! [Q. Why were they disturbed?] I think because they had never thought in terms of strategy. I think they may have been disturbed that when the work they had done was down in black and white it did not look like much, and also that their aims were more like ideals."(S9)*

The MAAG in this case has already been identified as having particularly unenthusiastic members, but a number of other support staff reported similar, if less extreme, responses from their members when challenged to define their roles. Among such respondents there was general agreement that the authors of the circular had paid too much attention to the size, shape and professional status of the MAAG and too little to how it would actually work in the hands of those appointed to take it forward.

**Funding**

As discussed in Chapter Six, there was considerable variation between the study MAAGs with regard to their basic funding allocations and the monies available to support their activities from other sources. Many respondents were aware of these differences and nobody knew quite how the allocations were determined at national level. But this variation and lack of clarity did not seem particularly concerning to most people, perhaps because most respondents thought their own MAAG was adequately funded, at least for the present. This does not mean that the money available was regarded as enough to get audit properly established - as indicated above, almost everyone believed this would require substantial sums going directly to practices. What it does appear to indicate, rather, is the acceptance of a rather modest role for the MAAG. FHSA respondents

thought MAAGs were unlikely to have sufficient impact to justify receiving more money. MAAG GP respondents felt they would be hard put to find ways of spending more money, given the very part-time nature of their commitment to the MAAG. Only some of the support staff disagreed. These people, who were thinking full time about audit, had plenty of suggestions to make about how more staff could constructively be employed to work with practices and some were quite frustrated by the limited ambitions of their employers.

For most respondents, the major issue of MAAG funding was uncertainty about the future. The MAAG circular had an expected life span of approximately three years with a specified cancellation date of 18 June 1994. (In fact the life of the circular was subsequently extended by a letter from the NHS Executive (Field 1994) until April 1996 when the new unitary health authorities were introduced, but at the time of interview nobody knew that this was going to happen.) There was a widespread belief that the original arrangements for "earmarked" funding were unlikely to continue beyond 1994 - if indeed they lasted that long - and a general expectation that monies for audit would diminish as other newer priorities emerged.

While most respondents believed that MAAGs would continue to exist in some form as long as the circular remained current, it was generally understood that discretion about funding levels would increasingly be devolved to individual FHSAs. Not surprisingly, most managers and medical advisers welcomed the prospect of greater influence over the activities of their MAAGs, but these opportunities for increased leverage were viewed with trepidation by many of the MAAG respondents, especially those whose relations with their FHSAs were already somewhat strained. In addition, while both MAAG and FHSA respondents accepted that future funding would depend on the MAAGs' capacity to produce some tangible results, it was widely acknowledged that the period of protected funding was likely to be too short for them to establish their worth before being called to account. As one of the coordinators summed it up:

> *"From where I sit the message comes loud and clear - people aren't thinking in terms of them having a long lifespan. Everything has short term stamped all over it - the longest contract is 12 months. The MAAGs themselves seem to be set up on a project basis, like an extension of the pilots. It reminds me a bit of training schemes, inner city initiatives etc. Government attempts to have a short blast at things and see what happens. They're not going to go on spending the money if all that comes back from MAAGs is: 60% of practices have done something*

*resembling an audit, but we can't tell you what, why, what the outcome was and whether it was of any benefit to anybody. Equally, GPs are more than ready to start resigning en masse if you start imposing things from outside. Therefore where do you go? I think it will get axed fairly soon or they'll try and control it a lot more - the FHSA must know what's happening to the money and what the outcome was." [Q. Do you think that would be feasible?] "Well quite a few of the members are quite good at jumping up and down saying they're going to resign, and yet these are supposedly the interested, non-frightened GPs, so...."(S6)*

Such gloom was not universal. On the contrary, several of the more enthusiastic managers had taken steps to reassure the MAAG that they valued it highly and would seek to continue or even increase its funding irrespective of what happened nationally. But in several of the study districts doubts about the future had already led to planning blight. In these places MAAG respondents claimed that lack of confidence had inhibited them from embarking on large scale or longterm projects, prevented them from offering sufficient job security to retain high calibre support staff and discouraged them from putting time and thought into developing methods of evaluating their work, since they did not expect the MAAG to last long enough to make this worthwhile.

**Specification of task**

As has already been discussed, the circular paid careful attention to the membership and structure of the MAAG. In comparison, the recommendations about how MAAGs should work with practices, what type of audit they should promote and how they should relate to the FHSA were kept deliberately brief and general to allow for local flexibility and evolution over time.

Respondents' views about the openness of the MAAG brief were very variable. As might be expected, most of those who were pleased with what was happening in their own districts saw the lack of direction as wholly beneficial:

*"The original circular was a masterly compromise - there was the leeway and freedom to initiate something different and innovative. It made things possible locally which it would have been impossible to negotiate nationally [such as recruiting someone from the community health council as a MAAG member]."(G15)*

But many of the rest had more ambivalent views. On the one hand it was acknowledged that those who wrote the circular were right not to attempt to define the MAAG's role more clearly because uncertainty about the nature and purpose of audit, the great

variation between districts and the novelty of the MAAG initiative made it impossible to predict exactly what would work best in all districts. On the other hand, the lack of specification was seen as a significant problem. A number of respondents from both MAAG and FHSA commented that MAAG members were "floundering" or "wallowing" because of inadequate direction and uncertainty about their rights and responsibilities with regard either to practices or the FHSA:

> *"Some more standardisation would have been very useful. Particularly some standardisation of what the FHSA is to expect and what we should expect from the FHSA would be very, very useful. They're the ones who are the professional managers and know how to get out of providing you with what you want. As it is we're on our own in [the health authority]. We don't fit into any directorate here, so nobody really knows what we're doing. If someone had agreed some sort of remit for us in the beginning everyone would be better able to judge how we are getting on now."(S3)*

Among the service oriented respondents who were most critical of the MAAG initiative, the lack of clarity within the circular about the MAAG's responsibilities was seen as symptomatic of the government's excessive concern to sell the audit policy to the profession. By underplaying essential aspects of the MAAG's function such as the need to promote audit of specific topics, it was felt that the circular had encouraged people to become MAAG members who had no intention of working constructively with the FHSA. In the view of these respondents, the ambiguities within the MAAG brief did not simply make it more difficult for the MAAG to work, rather they fundamentally threatened the success of the whole enterprise.

### *Views of the future*

As mentioned earlier, uncertainty about future funding was a major issue. Nevertheless, most respondents had clear ideas about how MAAGs would or should develop assuming funds remained available. As might be expected, most of the MAAG respondents who were sceptical about audit or government motivation were also pessimistic about the future, believing MAAGs would be dumped for failing to deliver or transformed into something much more coercive. Some of the FHSA respondents who were most negative about their own MAAGs agreed this was what ought to happen. But most people were much more optimistic about a continuing and evolving role for the MAAG.

Most of those who regarded the MAAG's function as specifically confined to establishing audit in primary care saw it as likely to achieve this task within a specified period of time - estimated at between three and five years from the present - and anticipated that it could then appropriately be disbanded. Some audit enthusiasts saw the job as taking longer to complete because they were more ambitious about developing high quality multidisciplinary audit and working at the interface with secondary care. But these respondents also envisaged a time when the MAAG would no longer be needed because audit would have become an integral aspect of professional health care practice.

In contrast, the great majority of respondents who saw value in the MAAG beyond its audit support function appeared to regard it as having a potentially permanent role. What exactly this role would be varied with the particular concerns of different respondents. Some thought the MAAG would become a research organisation within the FHSA, others thought it should be developed as a professional advisory group for the FHSA. A wide range of potential tasks for such a group were identified including evaluating changes in service provision, identifying opportunities for service innovation, evaluating practice demands for resources, developing acceptable systems of assessment, running practice accreditation, investigating local problems, promoting local strategies and developing other quality initiatives. The general assumption among FHSA respondents was that the MAAG would move away from focussing on the specific esoteric preoccupations of GPs. For their part, most MAAG respondents believed that irrespective of what else it did the MAAG should continue indefinitely as a generic support group for practices, whatever their needs might be.

## Chapter Ten

## ASSESSMENT

The purpose of the first part of this chapter is to consider how far the MAAGs in the study districts were working in accordance with the expectations of the MAAG circular and how far the anticipated benefits of the audit programme as envisaged in *Working for Patients* were already being realised or seemed likely to be realised in the future. This assessment is followed by a consideration of how MAAGs did in fact develop after 1993 which is based on evidence from a number of other sources including some of the later evaluation studies described in Chapter Four. The findings of the present evaluation and the other studies discussed are then used to draw some conclusions about the strengths and weaknesses of the MAAG programme over the whole five-year period during which the original circular held sway. The final part of the chapter contains a brief discussion of the new arrangements for supporting audit that were introduced after April 1996.

### *Were the study MAAGs working as intended?*

Table 10.1 summarises the intended functions of MAAGs as specified in the circular and assesses the extent to which the study MAAGs were carrying these out. As the table shows, all the MAAGs were doing some work with most practices, all were encouraging their practices to audit, almost all had some arrangements for monitoring and reporting to the FHSA and there was a general belief that participation in audit had increased.

However, in most respects the detailed expectations of the circular were not being met. A variety of reasons for this have been identified in the preceding chapters. Some aspects of the circular were ignored by the study MAAGs because they were seen as unacceptable (putting pressure on practices, consulting with the FHSA), inappropriate (focussing specifically on medical audit, providing education and facilitation only), unimportant (involving patients) or not immediate priorities (promoting interface audit). In contrast, other expectations - that MAAGs should encourage systematic audit, should evaluate progress and should report on the general results of the audit programme - were accepted

**Table 10.1: Comparison between recommendations in MAAG circular and actual activities of the study MAAGs**

| | Circular recommendations | Were the study MAAGs working as intended? |
|---|---|---|
| *Work with practices* | | |
| | MAAGs should... | |
| * | encourage and exhort all practices to participate in audit | Yes, providing encouragement, but little exhortation or serious pressure being applied. |
| * | concentrate on education and facilitation | Yes, but also providing finance and practical support. |
| * | support all practices | Yes, except for those that would not accept support. |
| *Approach to audit* | | |
| | MAAGs should... | |
| * | encourage regular and systematic audit | No, little attempt to make it either regular or systematic. |
| * | encourage **medical** audit | Not specifically, encouraging more or less any sort of audit. |
| * | make plans to audit services bridging hospital and community services | Yes, in some cases, but not a major priority. |
| * | ensure that patients' views and satisfaction are taken into account | No, very little evidence of concern about this. |
| *Monitoring and accountability* | | |
| | MAAGs should... | |
| * | keep records of problems identified and actions taken to remedy problems | No, mostly keeping some records but not of problems because need for confidentiality prevents them being identified and therefore precludes action by MAAG. |
| * | evaluate progress | Yes, in some cases, but concentrating on audit activity not impact and doubts about quality of data. |
| * | report on the general results of the audit programme | No, reporting on activity rather than results. |
| * | agree with the FHSA the programme and scale of audit activity | No, little input from the FHSA except for agreeing the budget. |
| *Specific objectives* | | |
| | MAAGs should... | |
| * | achieve the participation of all practices in audit by April 1992 | None had met this deadline. Few expected to achieve 100% participation and not all intended to try. It was thought participation had increased, but the evidence for this was of variable quality. |

as appropriate by the majority of respondents. Yet these, also, were widely disregarded because of lack of confidence about audit on the part of MAAG members, diffidence about making demands on fellow practitioners, lack of access to information and inadequate systems for obtaining it.

In several respects it did appear likely, however, that study MAAG activity would move closer in the future to matching what was required. For example, MAAGs were expecting to have to pay more attention to FHSA concerns in order to retain their funding. For their part, managers anticipated that growing familiarity and trust would increase the acceptability of FHSA input into MAAG strategy. Concern with the interface was expected to increase once the MAAGs felt they had got audit well launched in primary care, although it was still expected to be difficult to organise. Data collection about audit activity seemed likely to improve as MAAGs became more systematic in their approach and more practices were expected to allow access to their audit results as they gained in confidence.

In other areas, however, little change was anticipated. None of the MAAGs had any intention of forcing unwilling practices to do audit and few showed much interest in greater involvement of patients. The commitment to confidentiality which was built into the MAAG circular and supported by most MAAG respondents would continue to prevent them from obtaining systematic information about the effectiveness of their work.

***Were the expected benefits of audit being achieved?***

The 1989 working paper on medical audit identified a range of reasons for introducing a policy on audit. It suggested that an effective programme of medical audit would enable doctors and managers to improve the quality of care to patients, to develop services and to plan ahead. Such a programme would also help reassure doctors, patients and managers that the best quality of service possible within the available resources was being achieved (Department of Health 1989). Evidence from the present study in each of these respects is considered below.

*Improving quality of care*

As already discussed, none of the study MAAGs had obtained any systematic information about the impact of audit carried out by individual practices in their districts. Outcome data were expected to become available from the multi-practice audit projects that had been organised in some districts, but at the time of interview none of these were yet completed. Some MAAGs had data on the number of practices that had completed the audit cycle, but in most cases they did not know what the completed audits were about, whether they had resulted in benefical change or whether any such change had been sustained. Without such information it could not be assumed that patients had benefited. Most support staff could cite a few examples they had come across while working with practices where patient care appeared to have improved, but they were often cautious about attributing this benefit directly to audit or the MAAG and acknowledged that the improvement might have occurred for other reasons.

From the present study it is therefore impossible to say whether or not the audit programme was producing benefit to patients. However, given the uneven nature of the support that was being provided to practices for audit and respondents' general scepticism about the quality of the audit going on in their districts, it seems unlikely that many significant benefits would have been found at this early stage even if the appropriate data could have been obtained. Many practices were still at the stage of data gathering rather than implementing change and most MAAGs were still more interested in gaining trust than in pushing their practices to complete the cycle.

*Developing services and planning ahead*

Theoretically, there are a number of ways in which audit might be used to develop services. For example, audit might be undertaken to assess the impact of a service innovation. Alternatively the results of audit might help identify the need for new or different services. At the time of interview, however, lack of access to audit results precluded their use in planning and the MAAGs' unwillingness to be directive or to take direction from the FHSA militated against their undertaking any collaborative work involving service development at district level. Nevertheless, as discussed earlier, a number of such activities were cited by respondents as possible tasks for the MAAG in

the future. It is possible that individual practices were already using audit in this way, but no information was available to assess whether this was the case.

While audit was not yet being used to develop services, the MAAGs in the study districts were contributing to practice development simply by virtue of their contact with practices and the opportunities this offered to provide informal help with a wide range of personal, clinical or organisational problems, to introduce practices to others with similar needs, to pass on valuable information about access to local resources and to provide advocacy for practices in their negotiations with the FHSA. As stated earlier, many of the respondents regarded this aspect of MAAG activity as a central part of its role. It is also one area where there seems to be little doubt that the MAAG programme was having a beneficial effect.

*Reassuring doctors, patients and managers*

For the audit programme to provide reassurance to any of the above about the quality of service being achieved it would be necessary for the results of audit to be available for scrutiny. As has already been reiterated on several occasions, concerns about confidentiality meant that such results were not generally available within the study districts. For doctors undertaking audit, the extent to which they felt reassured by the activity would presumably depend on what their investigations revealed. Assessment of the impact of audit at this individual level was not looked at in the present study. For some of the clinicians who were members of the MAAG it appeared that involvement with the audit programme had opened their eyes to the variation in the quality of general practice within their districts. Far from reinforcing confidence, the main effect of this experience was rather to diminish complacency and raise concerns about the quality of care that was being achieved.

As far as patients were concerned, it seems questionable whether most people even knew of the existence of the audit programme or the MAAG. While it is possible that patients were told about audits being undertaken in their own practices, few of the study MAAGs appeared to have made any effort to inform the public about their activities or their findings. (The one exception was the chair of MAAG 2 who had sent copies of the

MAAG's annual report to the public library and the local MP. Having had neither feedback nor reply, however, he was not planning to bother to do this again.) If patients were not aware of what was going on, it follows that they could not be gaining reassurance from the programme.

As for managers, little of the information they wanted was available from the MAAG, even in those cases where it had been collected. For many, the main effect of the audit programme so far had been to reinforce their awareness of the independent stance of the medical profession and its resistance to accommodating management concerns in respect of clinical quality. Most managers believed that, with careful handling, these attitudes could be changed. But, until greater cooperation was achieved, there was relatively little in what the MAAGs were doing that was likely to increase their confidence.

In other ways, however, most respondents did seem to derive some reassurance from the existence of the MAAG. Those holding a professional view of audit felt that the non-contractual status of audit for GPs and the medical dominance of the MAAG confirmed the government's acceptance of their view that the maintenance of clinical quality could and should be left to the profession. Those who were advocates of the practitioner view appeared to believe that, for the present at least, the MAAG did give GPs something valuable for themselves. But for those who subscribed to the service view, the MAAG initiative offered no such gratification. As has already been discussed, these respondents were much the most critical of the MAAG initiative at both national and local level, regarding it as playing into the hands of the powerful clinical professions and doing little to ensure improved accountability to patients.

On the basis of these findings it must be concluded that the initial impact of the MAAG initiative in the study districts was rather modest. While some clear benefits have been identified these were not, for the most part, those that were explicitly intended by the policy. As far as the anticipated benefits were concerned there was little evidence of anything much to celebrate so far, though in some areas there appeared to be promise for the future.

This is, of course, only one study. It included just 15 of the 90 MAAGs in the country and took place when MAAGs were less than two years old. Nevertheless, the comparisons that were made in Chapters Five and Six against national data on demographic and health service characteristics of FHSA districts and with the findings of other studies of MAAGs indicate that, on almost every variable investigated, the study sample was not untypical of the larger group. The findings of the present study may therefore be taken to provide a reasonable picture of where the MAAG initiative nationally had got to by the winter of 1992/93.

### *Continuity and change over time*

As has already been discussed, the findings of the study enabled some predictions to be made about what would happen in the future. Writing now in 1996 it is possible to look back over the period since the study data were collected and look at how MAAGs actually did develop subsequently. Findings from some of the later evaluation studies described in Chapter Four and information provided by the National MAAG Coordinator, Caroline Lambert, who was informally monitoring the MAAG initiative at a national level are used below to summarise the main changes and continuities occurring within MAAGs after 1993.

#### *Structure*

While GPs continued to dominate the membership numerically, there has been a steady increase in the number of MAAGs including representatives of the primary health care team as members (C Lambert, personal communication). On the other hand, the number of MAAGs in which users are actively involved remains extremely small (Kelson and Redpath 1996). As far as day to day leadership of the MAAG is concerned, the trend towards greater involvement of lay support staff has continued and the centrality of their role is now acknowledged almost everywhere. For example, at the most recent National MAAG Conference held in February 1996 a debate was held on the motion: "This house believes that the lead person in MAAGs should be a non-medical audit manager". The motion was carried by 137 votes to 15.

While the MAAGs in the present study held a variety of contrasting aspirations and priorities, they were still very similar to one another in formal terms. Since then it appears that there has been much greater diversification both of structure and function as the paths of individual MAAGs have diverged - some towards a more explicit educational role with enhanced links to continuing professional education, others towards much closer identification with the health authority and more active involvement of management and public health (C Lambert, personal communication). In some cases these developments have been reflected in a modification of name such that the terms "medical" or "audit" have been dropped from the title and replaced by "clinical" or "quality". In a handful of districts MAAG disputes with the FHSA over strategy have led to complete deadlock and in some of these places the MAAG is no longer active. One of these is MAAG 9 which, in the present study, was the only one about which no respondent had anything positive to say.

*Activity*

The main source of systematic information about how the activities of MAAGs have evolved more recently is the 1994 national survey mentioned above (Humphrey and Berrow 1995). As described in Chapter Four, the findings of this study indicate that by the time of that survey most MAAGs were responding to the Department of Health's shift in emphasis from medical to clinical audit and from uni-disciplinary, within practice audit to multi-disciplinary, interface working. For example, only 26% of the MAAG chairs who responded regarded uni-disciplinary audit as a priority and only 42% said that their MAAGs were encouraging audit on individual practice interests. In contrast, over half of the chairs said that multidisciplinary audit, audit at the primary/secondary care interface, audit between primary care and community services and audit on topics of local or national concern were now priorities for their MAAGs. In addition, at least 30% of the MAAG respondents claimed that their MAAG had begun to assist the FHSA with the various wider developmental functions identified in the present study as possible areas for future collaboration. The great majority (82%) of FHSA respondents in the 1994 study thought their views about audit strategy had been taken account of by the MAAG and most were satisfied both with their opportunities for input into MAAG strategy and with what the MAAG was doing.

Substantially more information was being collected by MAAGs in 1994 than in the present study. For example, 81% of MAAG respondents claimed to have data on practice progress round the audit cycle, 93% said they knew something about what topics were being audited and 79% had some information about the outcome of audits undertaken. However, it is not clear how complete or systematic any of this information was and much of it was still not being passed on to the FHSA. Managers still wanted more information than they were getting and only 37% described themselves as satisfied with the data they did receive.

*Impact*

In the present study there was a general belief that more practices were engaged in audit than had been before, but the evidence for this belief was of variable quality. The findings of the survey undertaken by Baker and colleagues in 1994 (Baker et al 1995) appear to confirm and strengthen this claim, in that the percentage of practices per MAAG reported as undertaking either "full" or "any" audit rose year by year from 1991-2 to 1993-4. However, these authors reiterate the need to interpret their findings with caution because of the continuing unreliability of the methods used by MAAGs to collect their information.

As discussed in Chapter Four, the only systematic study undertaken to systematically assess the impact of MAAG-led audit was that commissioned by the NHS Executive from the Eli Lilly National Clinical Audit Centre and, at the time of writing, this study is not yet complete. Thus there is still no satisfactory information available about whether the work of MAAGs has led to benefits in patient care.

### *Conclusions on the strengths and weaknesses of the policy*

In their joint foreword to the NHS Management Executive's 1993 policy statement *Clinical Audit* (NHSME 1993b) the Chief Medical Officer and Chief Nursing Officer commended the audit initiative and all involved with it as follows:

> *"When Working for Patients was published in 1989 the government acknowledged the size of the challenge posed by its proposals on audit. Detailed and constructive dialogue was called for between management and the professions both locally and*

*nationally, to ensure that the approach adopted commanded professional support and was appropriate to local needs.*

*We have all come a long way since then. Medical audit has fulfilled the original expectations of it and audit in its wider sense has taken root in all the health care professions. We should like to take this opportunity to congratulate all those involved on the excellent progress which has been made to date in making audit a reality."*

With regard to primary care, the findings reported in this thesis confirm that by 1993 progress had certainly been made in getting audit established, though the extent to which it had actually "taken root" by then is questionable. As the analysis above has shown, both audit and the audit policy did indeed fulfil some of the expectations people had of them, but not all of these were positive and some important hopes were not realised. On the other hand some unanticipated benefits of the policy emerged during the course of its implementation and some anxieties about it turned out to be unfounded. Some conclusions about the main strengths and weaknesses of the audit policy in primary care are summarised below.

*Strengths*

Arguably the major achievement of the policy was the creation of the MAAGs themselves as viable, even flourishing, organisations. The MAAG was an unprecedented organisational structure, involving GPs working together at a district level and co-operating with the FHSA in ways that they had never done before. Moreover, the focus on audit meant that MAAGs would be working in an uncertain, controversial and highly sensitive area of policy and practice. It might seem, therefore, that the odds were stacked against success. And yet ... the great majority of MAAGs established themselves over the five years of their existence as enthusiastic, innovative and responsive agencies with a significant role in supporting development in primary care.

Paradoxically, the strength of the MAAGs lay, not in doing what was expected of them (as has been shown, they did not always do this very well), but in their capacity to move beyond the limitations of their brief. Thus, over time, they dealt with many of the problems which were anticipated by commentators at the outset and/or identified by

respondents in the present study. For example:

* *There was initial concern that audit would require more time, resources and skills than were provided for within the policy.* Most MAAGs, in collaboration with their managers, found ways of providing practices with financial support. Initially MAAG members lacked the skills and, in some cases, the confidence or motivation to organise themselves or to promote audit effectively. These things improved over time because of support staff taking a greater role.

* *There was concern that audit would serve as a diversionary device to paper over the cracks caused by insufficient resources.* In fact, audit was used as a means of identifying need. A number of MAAGs successfully supported practices in using audit as an argument for obtaining additional resources, equipment and staff for practice development from the FHSA. By 1994 over 40% of MAAGs were working with the FHSA in identifying opportunities for investment of resources in primary care.

* *There was concern that the audit policy focussed too narrowly on the medical profession, ignoring the role of the wider clinical team.* Primary health care team members were given no formal representation on MAAGs and the absence of any source of funding for practice staff equivalent to the PGEA allowance for doctors remained a problem. But, from the start, MAAGs focussed on clinical rather than medical audit and MAAG staff made considerable efforts to involve practice staff in education and audit projects. At a later date, MAAGs increasingly appointed other members of the primary health care team as members.

* *There was concern about what was regarded as an inappropriate separation between professional audit and other quality initiatives.* Initially, MAAGs had few links with other quality initiatives, except in some cases through support staff, and inadequate communication between the different areas was identified as a significant problem by medical advisers who were involved with both. Later on, however, cooperation between MAAGs and other aspects of the FHSAs' work on quality appears to have substantially increased.

* *There was concern that audit would be undertaken as "an end in itself" and that audit topics would be chosen for inappropriate reasons.* Most MAAGs regarded ease of study and interest of topic as valid criteria for choosing an audit, especially

for training purposes and, initially, importance to patients was not regarded as a priority. However, at a later stage MAAGs became less keen to support idiosyncratic audit and more willing to promote local and nationally identified priorities.

* *There was concern that poor dialogue betwen clinicians and managers and imposition of audit in a rigid manner would result in audit becoming a discredited, bureaucratic activity.* Most MAAGs and their managers managed to develop and sustain a relationship based on negotiation rather than imposition and, over time, to reach an accommodation about the type of work the MAAGs should be doing which was acceptable to all parties.

*Weaknesses*

The fact that the MAAG policy contained the potential for the kinds of problems outlined above to occur and depended so heavily on the competence and initiative of MAAGs on the ground to ensure that they were dealt with is, in itself, a major weakness. In those districts where either MAAG or management were particularly intransigent, moving the MAAG forward involved a lot of time and frustration and constructive progress was extremely slow. From the findings of the present study it appears that the most important factor in enabling most MAAGs to transcend at least some of these limitations was the quality and commitment of the lay support staff, yet the role of such staff was not even considered in the original circular.

A more serious failing of the policy was that it contained some basic flaws which the MAAGs could not, or at least did not, deal with effectively. First, as was pointed out by many commentators when it was first introduced, the arrangements for audit contained inadequate provision for lay involvement or public accountability. From the start, MAAGs had almost no formal lay representation and paid little attention to patient concerns and this was something that did not change significantly in subsequent years. Second, the policy placed excessive emphasis on maintaining confidentiality. In fact, MAAGs found confidentiality much easier to ensure than was initially anticipated. Problems arose, rather, from the fact that the maintenance of confidentiality limited access to audit findings and prevented MAAGs from using them constructively to resolve

problems or to assess or demonstrate impact. This remained a major weakness of the initiative throughout the lifetime of the MAAGs. Given the medical profession's deep-seated doubts about the clinical relevance of patient's views and its longstanding fears about external censure, it is perhaps not surprising that these two areas remained particularly intractable.

The most serious criticism of the audit policy at the time of its introduction was that it was based on assumptions about the value of audit for which there was not sufficient evidence. The most fundamental continuing weakness of the policy is that, despite the enormous amount of audit activity it generated, it failed to address this problem. Thus, after more than five years, the evidence about the benefits of audit - both in primary and secondary care - remains as shaky and inadequate as it was before 1989. The reasons for the continuing absence of sound data in primary care have already been discussed. Many, though not all of them relate to the problems of confidentiality described above. In secondary care, as is shown below, the picture is very similar.

The present state of knowledge about audit in the secondary sector and the problems in obtaining good quality data were summed up in the 1995 report by the National Audit Office (NAO) on *Clinical Audit in England* (NAO 1995). In its submission to the NAO enquiry, the NHS Executive acknowledged both that its information about the impact of audit was incomplete and that there were major difficulties in interpreting the evidence was available. Despite these problems, the Executive concluded that clinical audit was having a significant impact on clinical practice and organisation. It presented no evidence on the effect of clinical audit on quality of patient care or outcomes. The NAO's own investigation of progress was based on visits to three regional health authorities. It was claimed that about one third of audit projects undertaken locally during 1993-94 had led to changes in clinical care and that "some of these had led - and others may lead - to improved quality of patient care and outcomes"(NAO 1995 p3). However there was no independent verification of the regional reports on which these claims were based.

As mentioned in Chapter Four, a multi-stranded national evaluation of audit in the hospital and community health services was commissioned from CASPE Research. The

reports of this evaluation concluded that clinical audit had been established as part of clinical practice and health care provision and had caused or facilitated change in a wide range of areas (CASPE 1994 a,b). But they also acknowledged that monitoring of progress was difficult due to a general lack of well-focused objectives for audit programmes and low quality data, and that relatively few of the changes reported directly affected the quality of health care delivered to patients (Buttery et al 1995). Similarly a 1995 report on the audit activities of the medical royal colleges and their faculties in England commented that there was little possibility of evaluation since objectives of programmes were often poorly defined and noted that little formal evaluation of outcomes had been attempted (CASPE 1995).

During the period 1989-94 the NHS Management Executive provided £220 million for audit, including £42.2 million for primary care. A further £61 million was allocated in 1994-95. Given the uncertainties identified above, it is perhaps not surprising that the NAO report recommended increased attention to assessing both effectiveness of audit and evaluating its costs and benefits at local level.

*The future*

In the view of the NHS Executive, the initial phase of stimulating audit is now complete and responsibility for further development of clinical audit in the future will rest with local purchasers and providers of health care (NAO 1995). The arrangements for funding audit have altered since 1995 to reflect this transferred responsibility, with funds intended for clinical audit no longer separately identified in health authorities' general allocations. Arrangements for clinical audit after April 1996 are discussed in two letters from the NHS Executive, one for the initiative as a whole (NHSE 1995) and one for clinical audit in primary health care (NHSE 1996). The general emphasis in both of these is on maintaining continuity rather than making major changes.

From April 1996, the new unitary health authorities have the task of assuring their Regional Offices that:

*"They successfully coordinate clinical audit across all health care and collect*

*sufficient information to be certain that local clinical audit activity addresses local needs, involves consumers, demonstrates benefit and has become a routine part of the professional practice of health staff. They will also assess the impact of audit on professional and organisational development."(NHSE 1995)*

In looking at how to discharge these responsibilities, it is suggested that health authorities "should seek to build upon the strengths of the present arrangements, especially those managed by FHSAs in relation to primary care audit" and that support for negotiation and monitoring of audit within primary care in particular "could remain delegated to a multi-professional version of the successful Medical Audit Advisory Groups."

The principle of maintaining a separately defined audit support group for primary care is formally justified on the grounds that the relationship between health authority and primary care is rather different to that with trusts, but it also reflects recognition of the value of the MAAG as a focus for creative development well beyond audit:

*"Many audit groups have developed skills and roles which promote the broader development of primary care and lead to an expanding role for the group...Staff working in MAAGs have developed important skills and experience over the last five years. Steps should be taken to ensure that staff with these skills continue to make a contribution to the development of primary health care."(NHSE 1996)*

The letters do not go so far as to recommend specific funding for primary care audit support - such advice would be out of keeping with the commitment to delegated management - but they do suggest that:

*"Health authorities should consider very carefully the implications for the audit programme (and hence the authorities' ability to ensure the quality of patient care) of any proposed reduction in resources or staff [for primary care audit]."(NHSE 1996)*

Beyond this, they avoid giving any advice about how health authorities should organise their support for clinical audit. For example there is no equivalent of the prescriptive instructions about audit group membership contained in the earlier circulars. Instead, the focus has shifted to the arrangements for monitoring the process, with much more detailed discussion of the format of audit reports, the criteria against which audit activity should be measured and, for the first time, a definition of what might constitute an **effective** clinical audit programme (see Table 10.2).

**Table 10.2: Definition of effective clinical audit proposed by NHS Executive (NHSE 1995)**

| | | |
|---|---|---|
| Involves balanced topic selection | * | Effectiveness/cost-effectiveness |
| | * | Audit across the primary/secondary interface |
| | * | Involves the consumer |
| | * | Multi-professional |
| | * | Links with research and development |
| | * | Reflects health authorities', trusts' and GPs' priorities |
| Employs adequate audit processes | * | Robust and appropriate audit methodologies |
| Secures implementation of audit results | * | Involves managers |
| | * | Informs the commissioning process |
| | * | Links with education and training |
| | * | Informs the R & D agenda |
| Is comprehensive | * | Involves all aspects of health care |

As might be expected, the components of "effectiveness" embody all the shifts of emphasis in audit policy which took place between 1989 and 1996. What is notable, however, is that all the suggested criteria relate to type, quality or process of audit rather than evidence of impact on patient care. It appears from this that the assumption is still being made that good quality audit, done on important topics with appropriate consultation and participation will bring about the desired benefits. The continuing inadequacy of the evidence in this area is not referred to anywhere and the general tenor of the letters gives no indication of any fundamental doubts about the value of audit as a tool for improving patient care. The emphasis is rather on modifying, clarifying, extending and developing a programme implicitly assumed to be worthwhile.

Given the growing preoccupation with clinical effectiveness in the NHS and the pressure to ensure not only that practice but also policy is evidence-based, the apparent lack of concern about the paucity of evidence concerning the direct benefits of audit for patients is curious. One possible explanation is that the audit programme fulfils enough other functions, such as reassuring practitioners and supporting service development, that its

keep may be justified in these terms alone. An additional possibility is that audit is no longer regarded as the central mechanism for improving clinical care in the way that it was in 1989 and therefore less is now expected of it. This role has passed instead to clinical effectiveness and claims are now being made for the latter which in some cases equal the hyperbole associated with the early proclamations about audit. As part of this development the status of audit has been downgraded. Where before emphasis was placed on its unique qualities it is now seen as merely one of a number of tools available to assess and promote the uptake of evidence based practice. Similarly the audit programme has become simply "a part of the broader work" on improving clinical effectiveness.

## Chapter Eleven

# REFLECTIONS ON THE EVALUATION

The purpose of this final chapter is to return to the aims of the evaluation, to consider how far they have been achieved and to reflect on the appropriateness of the methods adopted and the timing of the study in relation both to the development of the MAAG initiative and the other evaluation studies that were undertaken. The output of the study is then considered in terms of how its findings were disseminated, how they were used and what effect they may have had on practice or policy.

### *Methodology*

The rationale for using qualitative research methods in health services research and evaluation was discussed in Chapter Four. It was suggested that such methods are of particular value for exploring behaviours, attitudes or interactions that are not amenable to quantitative research; for assessing the quality, as opposed to the quantity, of events occurring; and for providing explanation and understanding as well as detailed descriptive accounts. Attention was also drawn to ways in which qualitative methods may be used as a complement to other types of study. Insights gained from qualitative investigations may be used, for example, to validate and help explain the results of quantitative surveys or to identify topic areas where further, quantitative study is required.

The evaluation reported in this thesis had two main aims. First to "map" the MAAG programme as comprehensively as possible and, second, to use the knowledge and understanding gained from this exercise to assess and explain progress (or lack of it) towards achieving the objectives of the audit programme. In the foregoing chapters, findings from semi-structured interviews and information obtained from documentary sources have been used in a number of different ways to achieve the first objective. For example, data were presented on the structural characteristics and activities of the MAAGs showing both what they had in common and the nature of their differences. Information was provided on the quality of the work they were doing, for example with regard to

supporting audit in their practices, and on how the various stakeholders felt about the value of the MAAG. Analysis and explanation of these findings involved consideration of the demographic and policy environment within which the MAAGs were working, the resources available to them and the professional allegiance, personal characteristics and attitudes towards audit of the various participants. The nature of the information collected enabled a rounded picture of what was going on in the study MAAGs to be developed which was of a quite different order, in terms of depth, detail and explanatory power, to the findings of the various quantitative studies of MAAGs that were undertaken during the same period.

Comparison was then made between the intentions of the MAAG circular and what the findings showed the study MAAGs to be doing in practice. Insights gained from the study made it possible not only to identify discrepancies between intentions and practice, but also to provide some explanation of why these had occurred and to assess the probability of their being resolved. The findings were also used in respect of the general aims of the audit programme, to consider the likelihood that these aims would be met.

As was discussed in Chapter Ten, this evaluation did not obtain the type of information which would make it possible to say whether or not the audit programme was producing the anticipated benefits to patients. What it did do, however, was to make it clear why such information was not being generated by the MAAGs themselves. It did not obtain any information directly as to whether the audit programme was providing the intended reassurance, but it did make clear some of the reasons why both managers and the public were unlikely to feel particularly reassured. In respect of the third aim of the audit programme, which was to facilitate service development and planning, this evaluation showed how the MAAGs were assisting practice development in ways that had not been anticipated and often went well beyond audit.

Arguably, therefore, the study went some way towards achieving its objectives. It is important, however, to recognise its limitations. Perhaps the most important weakness was the lack of any direct observation of MAAG activities or independent data collection with regard, for example, to practice audit activities, which would have made it possible

to assess whether respondents were accurately reporting what was going on. As was explained in Chapter Five, practical constraints on time and resources prevented any such checks being made. A second significant limitation was the small number of people who were interviewed in each district. The under-representation of GP facilitators in particular has already been noted. Ideally it would have been preferable to talk directly to a wider range of MAAG members and to have obtained the views of local practitioners also.

### *Role in relation to other evaluation studies*

Whatever its strengths, a single study of any sort is unlikely to constitute an adequate evaluation of an initiative such as the MAAG programme. As all methodologies have their strengths, so they also have shortcomings. For example, qualitative studies cannot provide accurate information about the frequency of events in a population or the strength of statistical associations between particular variables. There is also unlikely to be any single moment during the life of a programme when an evaluation should take place. As was discussed in Chapter Four in relation to the MAAG initiative, different questions will arise at different stages. And, as the findings presented above have shown, answers to the same questions may alter over time as circumstances change and the initiative evolves. As Cronbach has observed (1982 p.19):

> *"Planning an evaluative enquiry is more like planning a campaign of investigation than planning a single experiment. Evaluation at its best is responsive to incoming observations and to the changing concerns of the policy community. Conclusions about programmes are based on the cumulations of findings and not on one study."*

As was mentioned earlier, evaluation of the MAAG initiative was not organised through one grand plan. Rather, a series of loosely connected projects developed over time. The evaluation described in this thesis was one of the earliest to be undertaken and might have been thought to be premature. As has been shown, however, even at this early stage the MAAGs in the study had already developed distinctive characteristics and some of the strengths of the initiative, as well as some of its enduring weaknesses, were already quite apparent. In other respects, as was anticipated, the findings of this study did become outdated. If the assessment of the policy as a whole which was made in Chapter Ten had

been based on this study alone, its conclusions would probably have been more negative than was warranted.

One advantage of doing this study early was that it provided extensive information about the MAAG initiative at the time when it was most needed, both because there was little available from other sources and because those involved with running MAAGs were at their least experienced. As these findings became less current, so they also became less necessary because better networks of communications had been established and more data appeared from other sources to complement or modify the earlier conclusions.

*Dissemination and use of findings*

The evaluation was originally commissioned by the NHS Executive for a very practical purpose - to provide systematic information about how MAAGs were working for all those who needed to know and specifically to place those involved with the development, modification or defence of the policy in a better position to fulfil those roles. It therefore seems appropriate to consider where the findings went to and what has been done with them in the three years since the data were collected.

The findings were disseminated by four different routes: i) presentations to and discussions with those directly involved with the study as subjects or sponsors; ii) briefing papers and presentations to support staff and clinicians in MAAGs and health authority managers at district and regional level through various national conferences; iii) verbal and written reports for the NHS Executive; and iv) published papers and reports. Details of these are shown in Table 11.1.

The extensive nature of the evaluation and the large amount of material collected made it both inappropriate and impracticable to report on all the findings in any one presentation. Instead, the reports involved a combination of brief summaries and more detailed discussion of particular issues. Nevertheless, because of the high levels of attendance at the various national meetings it is probable that knowledge about the study and at least some of its findings eventually reached a majority of those with a direct

interest in MAAGs.

**Table 11.1: Dissemination of findings from the qualitative evaluation of MAAGs**

*Study MAAGs* -

Two workshops held in the participating regions attended by 57 MAAG staff, members, FHSA managers and Department of Health representatives (1993)

*MAAGs and health authorities* -

Plenary presentations to three national MAAG conferences (1994,1995,1996)

Plenary presentations to two national conferences on clinical audit for FHSA managers (1993 and 1996)

Briefing paper and plenary presentation for a national conference for regional audit leads (1993)

*NHS Executive* -

Four reports on MAAG structure and organisation, MAAG finance, the educational role of the MAAG and multidisciplinary working and interface audit (1993)

*Publications* -

On the developing role of MAAGs (Humphrey and Berrow 1993)

On the progress of the MAAG initiative (Humphrey and Berrow 1994)

On evaluation of MAAGs (Humphrey 1994)

Following the initial dissemination, further opportunities arose at both local and national level to use the findings to facilitate discussion of particular issues. For example, in 1994 the author was invited by one of the study districts (District 1) to chair a meeting todiscuss the proposed transformation of the MAAG into a broader-based clinical audit group and to comment on the viability of the proposals. At about the same time a similar invitation came from District 14 to facilitate the first face to face meeting between the MAAG and FHSA management to discuss areas for potential collaboration. In this district the two organisations had a history of mutual antipathy and mistrust and it was felt by those involved that the presence of an informed outsider who could provide examples of how things were handled elsewhere would help defuse local tensions and broaden the

discussion. Three other districts that did not participate in the original study made comparable requests.

At a national level, the study was used by the NHS Executive in a number of ways. The findings provided the core explanatory content for the Department of Health's submission on audit in primary care to the National Audit Office enquiry on clinical audit in England. A modified version of this report was subsequently published by the Executive and distributed to all MAAGs, health authorities and other relevant organisations (Humphrey and Berrow 1994). Study reports were used as briefing papers for the Clinical Outcomes Group Primary Care Clinical Audit Sub-Committee and provided the basis for some sections of this group's subsequent report on the future of clinical audit in primary care (COG 1995). The study's identification of problematic aspects of the MAAG initiative led to further research being commissioned on MAAG accountability and involvement in collaborative work.

Thus the evaluation findings were both known about and made use of by at least some of those for whom they were intended. Whether the study actually made any difference to policy or practice is much less certain. Findings were cited earlier which showed that eighteen months later there were no differences between MAAGs who participated in the study and those that did not. At a local level, therefore, it seems unlikely that participation in the study had any significant effects. With regard to national policy, some of the emphases in the 1996 executive letter on primary care audit such as the stress on the service development role of the MAAG and the central importance of support staff resonate with the study findings and it may be that the evaluation contributed to recognition of these issues. But in other respects key weaknesses identified in the evaluation, such as the problems associated with the commitment to confidentiality, remain unaddressed. (The need for individual confidentiality is reiterated in the new advice.) In such areas it would be perhaps more surprising if action had been taken, since the political considerations which led to such commitments being made in the first place remain important irrespective of their demonstrably detrimental consequences.

In a discussion of the influence of research on policy, Walt (1994 p.234) argues that to

search for a direct connection between one "masterpiece of scientific discovery" and a specific policy is to misunderstand the nature of the policy environment. While new information and knowledge do percolate through the policy environment and become part of policy makers' thinking, they do this not in a clear linear fashion but in a much more diffuse way:

> *"The pattern of influence can be likened to water falling on limestone: the water is absorbed, but there is no knowing what route it will take through the different strata of stone or where it will come out."*

Walt suggests that it is necessary to take a longer view and look for the cumulative weight of a line of research which leads to a gradual encroachment on entrenched ideas or conventional wisdom. In considering the effects of an evaluation such as the present one on a policy area which is still changing month by month the same holds true. It is possible that, in the long run, the findings both of this study and of the thirteen other evaluative studies of MAAGs may turn out to have affected the longer term development of general practice audit in ways that are not yet apparent. At the moment it simply remains too soon to say whether this will be the case.

## REFERENCES


Adelaide Medical Centre Primary Health Care Team. A primary health care team manifesto. *British Journal of General Practice* 1990;41:31-3.

Anderson CM, Chambers S, Clamp M. Can audit improve patient care? Effects of studying the use of digoxin in general practice. *British Medical Journal* 1988;297:113-4.

Anon. Curtains up on the NHS review. *Lancet* 1989;I:247-9.

Armstrong D. Medicine as a profession: Times of change. *British Medical Journal* 1990;301:691-3.

Association of Community Health Councils for England and Wales. *Quality Assurance and the Role of Community Health Councils* London: Association of Community Health Councils for England and Wales, 1989.

Audit Commission. *Minding the Quality: A Consultation Document on the Role of the Audit Commission in Quality Assurance in Health Care* London: Audit Commission, 1992.

Audit Commission. *Briefing on GP Fundholding* London: Audit Commission, July 1995.

Baker R. Problem solving with audit in general practice. *British Medical Journal* 1990;300:378-80.

Baker R, Hearnshaw H, Cooper A, Cheater F, Robertson N. Assessing the work of medical audit advisory groups in promoting audit in general practice. *Quality in Health Care* 1995;4:234-9.

Beardow R. Medical audit: A regional perspective. *Primary Health Care Management* 1992;2:2-4.

Beecham L. Contract rejected; ballot called; more talks wanted. *British Medical Journal* 1989;299:57-60.

Black N. The relationship between evaluative research and audit. *Journal of Public Health Medicine* 1992;14:361-366.

Black N, Thompson E. Obstacles to medical audit: British doctors speak. *Social Science and Medicine* 1993;36:849-56.

Blakeway-Phillips C. What has organisational audit got to offer primary care? *Primary Care Management* 1993;3:7-8.

Berrow D, Humphrey C. Working together for quality improvement. *Audit Trends* 1996

(in press).

Berwick D. Continuous improvement as an ideal in health care. *New England Journal of Medicine* 1989;320:53-6.

Berwick DM, Enthoven A, Bunker JP. Quality management in the NHS: The doctor's role - I. *British Medical Journal* 1992;304:235-9.

British Medical Association. Evidence of Council to the Royal Commission on the National Health Service. *British Medical Journal* 1977;1:299-334.

British Medical Association. *Special Report of the Council of the British Medical Association on the Government's White Paper Working for Patients* London: British Medical Association, 1989.

Buckley EG. Activity, audit and accountability. *Journal of the Royal College of General Practitioners* 1989;39:3-4.

Buxton MJ. Achievements of audit in the NHS. *Quality in Health Care* 1994;3:Supplement:S31-S34.

Campling EA, Devlin HB, Lunn JN. *The Report of the National Confidential Enquiry into Perioperative Deaths* (NCEPOD report) London: National Confidential Enquiry into Perioperative Deaths, 1990.

Carr-Hill R, Dalley G. Assessing the effectiveness of quality assurance. *Journal of Management in Medicine* 1992;6:10-18.

Cartwright A, Anderson R. *Patients and their Doctors 1977* London: Institute for Social Studies in Medical Care, 1979.

Chambers R, Bowyer S. *An Evaluation of the Quality of Medical Audit in Primary Care* Unpublished report of a Department of Health funded project, 1993.

Chambers R, Bowyer S, Campbell I. Audit activity and quality of completed audit projects in primary care in Staffordshire. *Quality in Health Care* 1995;4:178-83.

Charlton JRH, Hartley RM, Silver R, Holland WW. Geographical variation in mortality from conditions amenable to medical intervention in England and Wales. *Lancet* 1983;1:691-6.

Charlwood P. Audit and Accountability. *Medical Audit News* 1991;1:34-6.

Clinical Outcomes Group Primary Health Care Clinical Audit Working Group. *Clinical Audit in Primary Care* Leeds: NHS Executive, 1994.

College of Health. *Ask The Patient. An Action Pack for GPs to get Feedback from their*

*Patients* London: College of Health in conjunction with Kensington, Chelsea and Westminster Family Health Services Authority, 1991.

Cooper A, French D. Illustrative examples of successful audit in general practice. *Audit Trends* 1993;1:166-9.

Cooper GL, Huitson A. An audit of the management of patients with epilepsy in thirty general practices. *Journal of the Royal College of General Practitioners* 1986;36:204-8.

Cox C, Mead A (eds). *A Sociology of Medical Practice* London: Collier-MacMillan, 1975.

Crawford M. A move towards coordinated practice. *Good Practice* April 1992:10-14.

Crombie DL. *Social Class and Health Status: Inequality or Difference* Occasional Paper 25. London: Royal College of General Practitioners, 1984.

Crombie IK, Davies HTO. Missing link in the audit cycle. *Quality in Health Care* 1993;2:47-48.

Cronbach LJ. *Designing Evaluations of Educational and Social Programmes* San Francisco: Jossey-Bass, 1982.

Day JL, Humphreys H, Alban-Davies H. Problems of comprehensive shared diabetes care. *British Medical Journal* 1987;294:1590-2.

Denzin NK. The logic of naturalistic enquiry. In NK Denzin (ed). *Sociological Methods: A Sourcebook* New York: McGraw-Hill, 1978.

Department of Health. *Working for Patients. Medical Audit* (Working Paper No.6) London: HMSO, 1989.

Department of Health (a). *Confidential Enquiry into Stillbirths and Deaths in Infancy: Report of a Working Group* London: Department of Health, 1990.

Department of Health (b). *Health Service Development - Working for Patients. Medical Audit in the Family Practitioner Services* (HC(FP)(90)8) London: Department of Health, 1990.

Department of Health. *Medical Audit in the Hospital and Community Health Services* (HC(91)2) London: Department of Health, 1991.

Department of Health. *Public Health Common Data Set 1995* London: Department of Health, 1995.

Department of Health and Social Security. *Priorities for Health and Personal Social Services* London: HMSO, 1976.

Derry J, Lawrence M, Griew K, Anderson J, Humphreys J, Pandher K. Auditing audits: The method of Oxfordshire Medical Audit Advisory Group. *British Medical Journal* 1991;303:1247-9.

Doyal L, Pennell I. *The Political Economy of Health* London: Pluto Press, 1979.

Drury M. Letters: The great NHS experiment. *Independent* March 22nd 1989.

Edwards MW, Forman WM, Walton J. Audit of abdominal pain in general practice. *Journal of the Royal College of General Practitioners* 1985;35:235-8.

Elcock H, Haywood S. *The Buck Stops Where? Accountability and Control in the National Health Service* Hull: University of Hull Institute of Health Services, 1980.

Emmanuel J, Walter N. Referrals from general practice to hospital outpatient departments: A strategy for improvement. *British Medical Journal* 1989;299:722-4.

Eynon-Lewis A. Audit of the management of pelvic inflammatory disease in general practice. *Journal of the Royal College of General Practitioners* 1988;38:492-3.

Fairbank JCT. Called to account. An orthopaedic surgeon. *Lancet* 1989;1:715-6.

Field R. Letter sent to chairmen of MAAGs. Leeds: Department of Health NHS Management Executive. May 16th 1994.

Fleming DM, Lawrence MSTA. Impact of audit on preventive measures. *British Medical Journal* 1983;287:1852-4.

Frater A, Spiby J. *Measured Progress: Audit for Physicians. A Manual of Theory and Practice* London: North West Thames Regional Health Authority Public Health Directorate, 1990.

Freidson E. *Profession of Medicine: A Study of the Sociology of Applied Knowledge* New York: Dodd Mead and Co. 1970.

Fry J. *General Practice: The Facts* Oxford: Radcliffe Medical Press, 1993.

Fullard E, Fowler G, Gray M. Facilitating prevention in primary care. *British Medical Journal* 1984;289:1585-7.

Gabbay J, Layton AJ. Evaluation of audit of medical inpatient records in a district general hospital. *Quality in Health Care* 1992;1:43-7.

Gau D, Pryce Jones M, Tippins D. Satisfactory practice. *Health Service Journal* 30 November 1989:1464-5.

Godfrey R. Called to account. A consultant physician. *Lancet* 1989;1:606.

Griew K, Mortlock M. A study of MAAG organisation and function. *Audit Trends* 1993;1:89-93.

Griffiths Report. *NHS Management Enquiry* London: Department of Health and Social Security, 1983.

Grol R, Mokkink H, Schellevis F. The effects of peer review in general practice. *Journal of the Royal College of General Practitioners* 1988;38:10-13.

Guba EG. *Toward a Methodology of Naturalistic Enquiry in Educational Evaluation* (CSE Monograph Series in Evaluation No.8) Los Angeles: Center for the Study of Evaluation, 1978.

Ham CJ. *Policy Making in the National Health Service* London: MacMillan, 1981.

Ham CJ. *Health Policy in Britain* (2nd edition) London: MacMillan, 1985.

Ham CJ (ed). *Health Care Variations. Assessing the Evidence* London: King's Fund Institute, 1988.

Ham CJ, Hunter D, Robinson R. Evidence based policymaking. *British Medical Journal* 1995;310:71-2.

Hancock C. Can it work for patients? *Senior Nurse* 1990;10(7):8-10.

Harris CM, Fry J, Jarman B, Woodman E. Prescribing - a case for prolonged treatment. *Journal of the Royal College of General Practitioners* 1985;35:284-7.

Harrison S. General management and medical autonomy in the National Health Service. *Health Services Management Research* 1989;2:38-46.

Harman D, Martin G. Managers and medical audit. *Health Services Management* April 1992:27-9.

Haywood SC, Alaszewski A. *Crisis in the Health Service: The Politics of Management* London: Croom Helm, 1980.

Her Majesty's Stationery Office. *Report of the Committee of Inquiry into Allegations of Ill Treatment of Patients and other Irregularities at the Ely Hospital, Cardiff* (Cmnd 3975) London: HMSO, 1969.

Hobbs R. Medical audit advisory groups and their links to medical schools. In R Baker (ed). *National MAAG Delegate Day 14 October 1993* (Conference Proceedings) University of Leicester: Eli Lilly National Clinical Audit Centre, 1994.

Hobbs CJ, Wynne JM. Diagnosing sexual abuse. *Lancet* 1987;II:1455.

Hopkins A. *Medical Audit Activities of the Royal Colleges and their Faculties in the UK* Leeds: Department of Health NHS Management Executive, 1994.

Houghton G, Sproston B. MAAGic powers. *Health Service Journal* 27 July 1995:28-9.

House E. *Evaluating with Validity* Newbury Park, California: Sage, 1980.

Hughes J, Humphrey C. *Medical Audit in General Practice: A Practical Guide to the Literature* London: King's Fund Centre, 1990.

Humphrey C, Hughes J. *Audit and Development in Primary Care* London: King's Fund Centre, 1992.

Humphrey C, Berrow D. Developing role of medical audit advisory groups. *Quality in Health Care* 1993;2:232-8.

Humphrey C, Berrow D. *Medical Audit in Primary Care: A Collation of Evaluative Projects* Leeds: Department of Health NHS Management Executive, 1994.

Humphrey C, Berrow D. Promoting audit in primary care: Roles and relationships of medical audit advisory groups and their managers. *Quality in Health Care* 1995;4:166-73.

Hunter DJ. Managing medicine: A response to the "crisis". *Social Science and Medicine* 1991;32:441-9.

Illich I. *Medical Nemesis* New York: Bantam Books, 1977.

Irvine D. *Standards in General Practice: The Quality Initiative Revisited* The 1989 Gale Lecture. London: Royal College of General Practitioners, 14 October 1989.

Irvine D, Irvine S (eds). *Making Sense of Audit* Oxford: Radcliffe Medical Press, 1991.

Jones R, Spencer J. Teaching old docs new tricks: research dissemination and professional behaviour change. (Conference report) *Family Practice* 1993;10:229-30.

Jost TS. Recent developments in medical quality assurance and audit. In R Dingwall, P Fenn (eds). *Quality and Regulation in Health Care* London: Routledge, 1992.

Joule N. *User Involvement in Medical Audit* London: Greater London Association of Community Health Councils, 1992.

Keeble BR, Chivers CA, Gray JAM. The practice annual report: Postmortem or prescription? *Journal of the Royal College of General Practitioners* 1989;39:467-9.

Kelson M, Redpath L. Promoting user involvement in clinical audit: surveys of audit committees in primary and secondary care. *Journal of Clinical Effectiveness* 1996;1:14-18.

Kerrison S, Packwood T, Buxton M. *Medical Audit: Taking Stock* London: King's Fund Centre, 1993.

Kind P. *Hospital Deaths - The Missing Link: Measuring Outcome in Hospital Activity Data* Discussion Paper 44. University of York: Centre for Health Economics, 1986.

Klein R. *The Politics of the National Health Service* London: Longman, 1983.

Lawrence M, Griew K, Derry J, Anderson J, Humphreys J. Auditing audits: Use and development of the Oxfordshire Medical Audit Advisory Group rating system. *British Medical Journal* 1994;309:513-6.

Lilleyman JS. Called to account. A haematologist. *Lancet* 1989;1:545-6.

Liverpool Family Health Services Authority Medical Audit Advisory Group. *Cooking the Audit Book: A Recipe for Success?* Liverpool: Liverpool Family Health Services Authority, 1990.

Lincolnshire Medical Audit Advisory Group *Annual Report 1992-93* Lincoln: Lincolnshire Family Health Services Authority, 1993.

Macpherson D, Mann T. Medical audit and quality of care - a new English initiative. *Quality Assurance in Health Care* 1992;4:89-95.

Maitland JM, Reid J, Taylor RJ. Two stage audit of cerebrovascular and coronary heart disease risk factor recording: The effect of case finding and screening programmes. *British Journal of General Practice* 1991;41:144-6.

Mant D, McKinlay C, Fuller A, Randall T, Fullard EM, Muir J. Three year follow up of patients with raised blood pressure identified at health checks in general practice. *British Medical Journal* 1989;298:1360-2.

Marinker M. Performance review and professional values. In DA Pendleton, TPC Schofield, M Marinker (eds). *In Pursuit of Quality* London: Royal College of General Practitioners, 1986.

Marsh P, Kendrick D, Williams EI. The impact of audit on the recording of childhood accidental injury information by primary health care teams. *Audit Trends* 1995;3:47-52.

Maynard A. Case for auditing audit. *The Health Service Journal* 18 July 1991:26.

McKeown T. *The Role of Medicine* Oxford: Blackwell, 1979.

McKinlay C. Rent-an-Audit: An educational exercise facilitating change. *European Newsletter on Quality Assurance* 1987;4:5.

McPherson K, Wennberg JE, Hovind OB, Clifford P. Small-Area variations in the use

of common surgical procedures: An international comparison of New England, England and Norway. *New England Journal of Medicine* 1982;307:1310-4.

Merrison A. *Royal Commission on the National Health Service* London: HMSO, 1979.

Metcalfe DHH. Audit in general practice. *British Medical Journal* 1989;299:1293-4.

Metcalfe DHH. "No Excuses." In DJ Pereira Gray (ed). *The Medical Annual 1985* Bristol: John Wright, 1985.

Metson D. Lessons from an audit of unplanned pregnancies. *British Medical Journal* 1988;297:904-6.

Ministry of Health. *A National Health Service* London: Ministry of Health, 1944.

Moores B. The need for medical audit. *Journal of Management in Medicine* 1989;3:323-339.

Morgan M. Variations in length of stay at district level. In C Ham (ed). *Health Care Variations. Assessing the Evidence* London: King's Fund Institute, 1988.

Moulds A. How to develop a clinical practice protocol. *Update* 1989;33:1157-1160.

National Audit Office. *Quality of Clinical Care in National Health Service hospitals* House of Commons Paper 736. London: National Audit Office, 1988.

National Audit Office. *Clinical Audit in England. Report of the Comptroller and Auditor General* London: National Audit Office, 1995.

NHS Executive. *The New Health Authorities and the Clinical Audit Initiative: Outline of Planned Monitoring Arrangements* (EL(95)103) Leeds: Department of Health NHS Executive, 1995.

NHS Executive. *Arrangements for Clinical Audit in Primary Care* (EL(96)16) Leeds: Department of Health NHS Executive, 1996.

NHS Management Executive. *Steering the Audit Programme* (Internal Discussion Paper) London: Department of Health NHS Management Executive, 1991.

NHS Management Executive (a). *The Quality Journey. A Guide to Total Quality Management in the NHS* Leeds: Department of Health NHS Management Executive, 1993.

NHS Management Executive (b). *Clinical Audit. Meeting and Improving Standards in Health Care* Leeds: Department of Health NHS Management Executive, 1993.

NHS Management Executive (a). *Medical Audit in the Hospital and Community Health*

*Service* Leeds: Department of Health NHS Management Executive, 1994.

NHS Management Executive (b). *Clinical Audit in the Nursing and Therapy Professions* Leeds: Department of Health NHS Management Executive, 1994.

NHS Management Executive (c). *Clinical Audit: 1994/95 and beyond* (EL(94)20) Leeds: Department of Health NHS Management Executive, 1994.

Needham AM, Brown M, Freeborn S. Introduction and audit of a general practice antibiotic formulary. *Journal of the Royal College of General Practitioners* 1988;38:166-7.

Newcastle upon Tyne Family Health Services Authority Medical Audit Advisory Group. *Learning by doing. The Chairman's report on a pilot study* Newcastle: Newcastle Family Health Services Authority, 1990.

Newton J, Hutchinson A, Steen N, Russell I, Haimes E. Educational potential of medical audit: Observations from a study of small groups setting standards. *Quality in Health Care* 1992;1:256-9.

North of England Study of Standards and Performance in General Practice. *Medical Audit Tools* University of Newcastle upon Tyne: Centre for Health Services Research Ambulatory Care Programme, 1991.

North of England Study of Standards and Performance in General Practice. Medical audit in general practice. I: Effects on doctors' clinical behaviour for common childhood conditions II: Effects on patients with common childhood conditions. *British Medical Journal* 1992;304:1480-8.

O'Dowd TC. Five years of heartsink patients in general practice. *British Medical Journal* 1988;297:528-30.

Parker J, Barnes S. Auditing audits. *British Medical Journal* 1992;304:254.

Patton MQ. *How to Use Qualitative Methods in Evaluation* California: Sage, 1987.

Peter L, Tate JB, Catchpole PJ. Practice activity analysis: Collaboration between general practitioners and a family practitioner committee. *Journal of the Royal College of General Practitioners* 1989;39:297-9.

Peters TJ, Waterman RH. *In Search of Excellence: Lessons from America's Best-run Companies* New York: Harper and Row, 1982.

Pfeffer N, Coote A. *Is Quality Good for You?* Social Policy Paper No. 5. London: Institute for Public Policy Research, 1991.

Philp I, Young J. Audit of support given to lay carers of the demented elderly by a

primary care team. *Journal of the Royal College of General Practitioners* 1988;38:153-5.

Pitts J. Whitby M. Out of hours workload of a suburban general practice: Deprivation or expectation. *British Medical Journal* 1990;300:111-5.

Pollitt C. Doing business in the temple? Managers and quality assurance in the public services. *Public Administration* 1990;68:435-52.

Pollitt C. (a) The struggle for quality: The case of the National Health Service. *Policy and Politics* 1993;21:161-170.

Pollitt C. (b) The politics of medical quality: Auditing doctors in the UK and the USA. *Health Services Management Research* 1993;6:24-34.

Pope C, Mays N. Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *British Medical Journal* 1995;311:42-5.

Powles J. On the limitations of modern medicine. *Science, Medicine and Man* 1973;1:1-30.

Pringle M. Medical audit in primary health care - the way forward. *Primary Health Care Management* 1990;1:2-3.

Richards J. How does audit make you feel? *British Medical Journal* 1991;303:1275.

Richardson A, Sykes W, Duggan M. *The Impact of Audit on Prescribing in General Practice* University of Leeds: Nuffield Institute for Health, 1993.

Robinson R, LeGrand J (eds). *Evaluating the NHS Reforms* London: King's Fund Institute, 1994.

Royal College of General Practitioners. *What Sort of Doctor?* London: Royal College of General Practitioners Report from General Practice 23, 1985.

Royal College of Physicians of London. *Medical Audit: A First Report: What, Why and How?* London: Royal College of Physicians of London, 1989.

Royal College of Surgeons of England. *Guidelines to Clinical Audit in Surgical Practice* London: Royal College of Surgeons of England, 1989.

Savage W. *A Savage Enquiry: Who Controls Childbirth?* London: Virago, 1986.

Savage R. Continuing education for general practice: A life long journey. *British Journal of General Practice* 1991;41:311-4.

Schofield TPC, Pendleton DA. What sort of doctor? In DA Pendleton, TPC Schofield,

M Marinker (eds). *In Pursuit of Quality* London: Royal College of General Practitioners, 1986.

Secretaries of State for Social Services, Wales, Northern Ireland and Scotland (a). *Working for Patients* (Cm 555) London: HMSO, 1989.

Secretaries of State for Social Services, Wales, Northern Ireland and Scotland (b). *General Practice in the National Health Service: The 1990 Contract* London: HMSO, 1989.

Shaw CD. Aspects of audit: The background. *British Medical Journal* 1980;280:1256-8.

Shaw CD. *Quality Assurance - What the Colleges are Doing* London: King's Fund, 1986.

Shaw CD. *Joint Guidelines on Assessment of Specialty Medical Audit* London: King's Fund Centre, 1989.

Shaw CD, Costain DW. Guidelines for medical audit: Seven principles. *British Medical Journal* 1989;299:498-9.

Spencer J. Audit and academic departments of general practice: A survey in the United Kingdom and Eire. *British Journal of General Practice* 1992;42:333-5.

Spratley J. *Joint Planning for the Development and Management of Disease Prevention and Health Promotion Strategies in Primary Health Care. The Health Education Authority Workshop Programme for the Development of Local Organising Teams Evaluation Report* London: Health Education Authority, 1990.

Standing Committee on Postgraduate Medical Education (a). Response to the White Paper *British Medical Journal* 1989;299:509.

Standing Committee on Postgraduate Medical Education (b). *Medical audit: The Educational Implications* London: Standing Committee on Postgraduate Medical Education, 1989.

Stone DH. Proposed taxonomy of audit and related activities. *Journal of the Royal College of Physicians of London* 1990;24:30-1.

Taylor MP. Epilepsy in a Doncaster practice: Audit and change over eight years. *Journal of the Royal College of General Practitioners* 1987;37:116-9.

Townsend P, Davidson N (eds). *Inequalities in Health* Harmondsworth: Penguin, 1982.

Turner D. Medeconomics poll reveals GPs have little faith in proposals. *Medeconomics* March 1989.

United Kingdom Departments of Health. *Report on confidential enquiries into maternal*

*deaths in the UK 1985-7* London: HMSO, 1991.

Walshe K, Coles J (a). *Evaluating Audit in the NHS. A Review of Initiatives* London: CASPE Research, 1993.

Walshe K, Coles J (b). *Evaluating Audit in the NHS. Developing a Framework* London: CASPE Research, 1993.

Walt G. How far does research influence policy? *European Journal of Public Health* 1994;4:233-5.

Webb SJ, Dowell AC, Heywood P. Survey of general practice audit in Leeds. *British Medical Journal* 1991;302:390-2.

Wilkin D, Smith T. *Variation in GP Referrals to Consultants* Manchester: University of Manchester Centre for Primary Care Research, 1986.

Williamson V. Patients' satisfaction with general practitioner services: A survey by a community health council. *Journal of the Royal College of General Practitioners* 1989;39:452-5.

Wilson A. Cervical cytology in the Vale of Trent Faculty of the Royal College of General Practitioners, 1985-8. *British Medical Journal* 1990;300:376-8.

World Health Organisation *The Principles of Quality Assurance* Report on working group meeting convened by Regional Office for Europe (Copenhagen) in Barcelona, 1983. European Reports and Studies, 94. Copenhagen: World Health Organisation, 1985.

World Health Organisation Regional Office for Europe. *Targets for Health for All* Copenhagen: World Health Organisation, 1985.

Yates J, Davidge M, Harley M, Vickerstaff L, Wood K. Comparing performance. *NAHA (National Association of Health Authorities) News* 1985;Issues 83,84,86,88: Supplements.

**APPENDIX A: Example of letter sent to FHSA chief executives requesting participation in the study**

2 November 1992

Dear Mr. A.

Re. Study of Medical Audit Advisory Groups

I am writing with regard to a national study of the role, composition, objectives and activities of the recently established medical audit advisory groups which I have been commissioned to carry out by the Department of Health. A summary of the project is enclosed with this letter. The 18-month study is being carried out in two regions, Y. and Z. The 15 MAAG Chairs in the two regions have unanimously agreed to take part in the study, which involves interviews with key people involved in the setting up and running of the MAAG in each FHSA district. In each case we will be talking to the MAAG chair and MAAG officers.

It is essential that we also obtain the FHSA perspective on the role of MAAGs. We would therefore like to interview the Chief Executive of every FHSA in the two Regions, the Medical Adviser and any other senior staff who have been particularly involved with the activities of the local MAAG.

I am writing to you as Chief Executive of the FHSA to ask whether you are willing to participate in the study and to suggest some possible dates when I or my co-researcher might come to interview you. The suggested date for interview would be some time during the week beginning 30 November. My secretary will telephone you within the next fortnight to confirm the arrangements. The interview will last approximately one hour and will cover:

* the setting up and constitution of the MAAG
* the role, objectives and activities of the MAAG
* issues of decision-making and accountability
* means of evaluating the work of the MAAG
* the relationship between the MAAG and other local health care agencies

In each area we are concerned to explore the views of all those involved regarding the strengths and weaknesses of the present arrangements for coordinating audit in primary care through MAAGs and to identify needs and suggestions for how things should develop in the future.

The information collected from all 15 districts in the study will be collated in an interim report which we will present for comment and discussion at two half-day workshops to be held in the two regions in March 1993. Everyone who has participated in the study will be invited to attend one of the workshops. Comments from the workshops will then be incorporated in the final report on the study.

I am also writing to your Medical Adviser Dr. W. with a similar request for an interview. If there are any additional members of the FHSA to whom you think we should speak, perhaps you could let us know so that we may approach them as well.

I hope very much that you will agree to take part and I look forward to meeting you. In the meantime, if you have any queries about the study, please do not hesitate to contact me.

Yours sincerely,

Charlotte Humphrey
Lecturer in Medical Sociology

## APPENDIX B: MAAG EVALUATION INTERVIEW SCHEDULE

*For each respondent check role, how long in post and where worked previously.*

*For each MAAG get list of MAAG members and what they represent.*

*For all question areas get respondent to assess strengths and weaknesses of present arrangements and desirable/likely changes. Is their view shared by others?*

### 1. SETTING UP AND MEMBERSHIP OF THE MAAG

1.1 When was it established?
1.2 Who was involved in setting it up?
1.3 Was it easy/difficult to get members?
1.4 Factors considered in the appointment of members?
1.5 What constituencies are represented?
1.6 How are members nominated?
1.7 How long do they serve for?
1.8 How representative of local GPs is the MAAG?

### 2. LOCATION OF THE MAAG

2.1 Previous, present and future location of MAAG office?
2.2 How/by whom was it decided where the MAAG office would be?
2.3 Good and bad things about the present location?

### 3. MAAG MEMBERS AND EMPLOYEES

*Members*

3.1 How is the work of the MAAG shared out between the members?
3.2 Role of the MAAG chair?
3.3 Role of medical adviser?

*Employees*

3.4 Who? Background? Role/tasks?
3.5 How much direction do they get from the MAAG?
3.6 Do they have direct links with the FHSA?
3.7 To whom are they accountable?
3.8 What kind of contract do they have?

### 4. MEETINGS

4.1 How often does the MAAG meet?
4.2 Who is invited to attend the meetings?
4.3 What happens at the meetings?
4.4 Are the meetings productive?

## 5. FINANCE

5.1 How much money does the FHSA spend on the MAAG?
5.2 How much of this is allocated directly to the MAAG?
5.3 How is the funding level decided?
5.4 Is the MAAG adequately funded?
5.5 What happens to any underspend?
5.6 How are the MAAG's funds managed?
5.7 How was all of this decided?
5.8 Do the arrangements suit everyone?
5.9 How will money be allocated to the MAAG in future?
5.10 What will/could the MAAG do to be more sure of obtaining funding in the future?
5.11 How are MAAG members paid?

## 6. RELATIONSHIPS WITH OTHER AGENCIES

*MAAG and FHSA*

6.1 How good are relations?
6.2 How tight are the links?
6.3 Nature of contacts between MAAG staff and members and FHSA staff?
6.4 To whom in the FHSA is the MAAG accountable?
6.5 Is there any negotiation between FHSA and MAAG about what the MAAG should be doing?
6.6 Since the MAAG was set up has the FHSA tried to intervene in any way?
6.7 What else is going on in the FHSA to do with audit or quality assurance?
6.8 Does the MAAG have anything to do with this?

*MAAG and DHA*

6.9 Is the FHSA district coterminous with the DHA?
6.10 What contact does the MAAG have with other local audit groups?

*Education*

6.11 What links does the MAAG have with the educational aspects of general practice?

*LMC and MAAG/FHSA/GPs*

6.12 How close are links between the MAAG and the LMC?
6.13 How are relations between the LMC and the FHSA?
6.14 How are relations between the LMC and local GPs?
6.15 How are relations between FHSA and local GPs?
6.16 Does the state of these relationships affect the MAAG?

*MAAG and other MAAGs*

6.17 What contact?

## 7. LOCAL BACKGROUND

7.1 How many practices are there in the district?
7.2 How many GPs?

7.3 What is the general morale of primary care like locally?
7.4 How is fund-holding developing in this area?
7.5 Are there any particular problems or needs?
7.6 How have local circumstances influenced the strategy of the MAAG?
7.7 What is the general attitude of local GPs to audit?
7.8 Is it known what proportion of local practices are doing audit?
7.9 How does the MAAG find out what individual practices are doing in the way of audit?
7.10 Which kinds of practices make most use of the MAAG's resources?
7.11 Has the MAAG ever had to say 'no'?
7.12 Are many GPs not involved with the MAAG at all?
7.13 Will the MAAG do anything about this?
7.14 Should audit be a contractual requirement for GPs?

## 8. AIMS AND OBJECTIVES

8.1 What are the overall aims of the MAAG?
8.2 Does the MAAG have specific written objectives?
8.3 Who agreed them - were the employees or the FHSA involved?
8.4 Who knows what they are?
8.5 Do they contain specific targets/timetables?
8.6 Were last year's objectives achieved?
8.7 Does the MAAG have an agreed programme of work for the present year?
8.8 How is MAAG policy decided?
8.9 What is the input from outside the MAAG?

## 9. ACTIVITIES OF THE MAAG

*(Explore extent to which MAAG is proactive/reactive in each area)*

9.1 MAAGS up and down the country have been doing a multitude of different things. Has your MAAG been involved in any of the following:-
* Identifying what audit is going on locally
* Disseminating information locally
* Training about audit
* Supporting audit in individual practices
* Supporting audit beyond individual practices
* Helping to deal with problems identified by audit

9.2 What difference has the MAAG made?
9.3 Which of these activities takes up the most time?
9.4 What is the most important role of MAAG?
9.5 Overall is the MAAG approach interventionist or responsive?

## 10. EVALUATION

10.1 Does the MAAG have a definition of what it regards as audit?
10.2 Does the MAAG attempt to assess the quality of audits it finds going on in practices?
10.3 What criteria does it use to assess quality of audit?
10.4 Does the MAAG have a view about what topics audit should cover?
10.5 What is the main value to practices of doing audit?
10.6 Does the MAAG fulfil a wider developmental role as well?
10.7 How does the MAAG review its own work?
10.8 What criteria would the MAAG use to judge its own success or failure?

10.9 How does the FHSA review MAAG activities?

## 11. PERCEPTIONS OF THE MAAG's ACHIEVEMENTS

11.1 Are you pleased with the progress of the MAAG so far?
11.2 What have been its main achievements and shortcomings?
11.3 How does it compare with other MAAGs?
11.4 What have been the main benefits of having the MAAG so far?
11.5 Have there been any disadvantages?
11.6 What changes have occurred in the role of the MAAG up to this point?
11.7 Are there any constraints on the MAAG which impede its work?

## 12. THE FUTURE

12.1 What will the future hold for MAAGs?
12.2 Does the MAAG have a natural lifespan? Will it become redundant or will it be transformed to something else?
12.3 Would there be another, better way to assure quality of care in general practice?
12.4 In what way would you like to see this MAAG develop?

*(Check whether they have any questions, further comments. Inform about workshop.)*

**END**

**APPENDIX C: Chi-square comparisons (with Yates' correction) between study MAAGs (n=14) and other MAAGs (n=76 where data come from MAAG chairs; n=71 where data come from FHSA managers) on 37 variables for which information was available from 1994 national study of MAAG accountability (Humphrey and Berrow 1995)**

| **A) MAAG priorities for audit** | Study MAAGs (n=14) | Other MAAGs (n=76) | |
|---|---|---|---|
| 1. Individual practice audit is a priority | 9 | 31 | p=0.18 |
| 2. Inter-practice audit is a priority | 7 | 29 | p=0.59 |
| 3. District-wide audit is a priority | 8 | 29 | p=0.30 |
| 4. Single-discipline audit is a priority | 6 | 17 | p=0.20 |
| 5. Multi-disciplinary audit is a priority | 6 | 39 | p=0.77 |
| 6. Primary/secondary interface is a priority | 5 | 39 | p=0.43 |
| 7. GP/community interface is a priority | 5 | 30 | p=0.97 |
| 8. Individual interests are a priority | 8 | 30 | p=0.35 |
| 9. Local topics are a priority | 6 | 37 | p=0.91 |
| 10. National topics are a priority | 5 | 34 | p=0.74 |

| **B) MAAG is helping FHSA** | Study MAAGs (n=14) | Other MAAGs (n=76) | |
|---|---|---|---|
| 11. To evaluate changes in service provision | 5 | 23 | p=0.90 |
| 12. To identify opportunities for innovation | 4 | 34 | p=0.41 |
| 13. To assess practice needs | 7 | 52 | p=0.30 |
| 14. To evaluate practice demands | 2 | 25 | p=0.28 |
| 15. To develop guidelines | 7 | 56 | p=0.15 |
| 16. To develop quality initiatives | 5 | 35 | p=0.95 |

| **C) MAAG is providing information to FHSA** | Study MAAGs (n=14) | Other MAAGs (n=76) | |
|---|---|---|---|
| 17. On number of practices auditing | 13 | 69 | p=0.99 |
| 18. On number of audits per practice | 4 | 19 | p=0.96 |
| 19. On topics audited | 12 | 55 | p=0.47 |
| 20. On practice progress round audit cycle | 6 | 35 | p=0.94 |

| | | | |
|---|---|---|---|
| 21. On change achieved through audit | 6 | 35 | p=0.94 |
| 22. On staff involved in audit | 5 | 30 | p=0.97 |
| 23. On attitudes to audit | 8 | 29 | p=0.30 |
| 24. On attitudes to MAAG | 8 | 24 | p=0.13 |
| 25. On non-auditing practices | 5 | 14 | p=0.27 |
| 26. On practice requests for help | 7 | 25 | p=0.36 |
| 27. On problems faced by practices | 6 | 39 | p=0.77 |
| 28. On financial support given to practices | 10 | 50 | p=0.92 |
| 29. On practical help given to practices | 8 | 36 | p=0.70 |
| 30. On education provided for GPs | 12 | 60 | p=0.83 |
| 31. On education provided for phct | 7 | 57 | p=0.12 |
| 32. On participation in education | 7 | 41 | p=0.98 |
| 33. On participant feedback on courses | 7 | 31 | p=0.73 |

| **D) FHSA manager satisfaction with MAAG** | Study MAAGs (n=14) | Other MAAGs (n=71) | |
|---|---|---|---|
| 34. Satisfied with MAAG audit strategy | 10 | 34 | p=0.26 |
| 35. Satisfied with information from MAAG | 6 | 25 | p=0.81 |
| 36. Satisfied with arrangements for contact | 10 | 31 | p=0.11 |
| 37. Satisfied with FHSA opportunities for input | 10 | 37 | p=0.30 |

HEALTH CIRCULAR

HC(FP)(90)8
HC(90)15

# DEPARTMENT OF HEALTH

To: Family Practitioner Committees - for action

Regional Health Authorities
District Health Authorities
Special Health Authorities for London Postgraduate Teaching Hospitals
Local Medical Committees
Community Health Councils
) for information

HEALTH SERVICE DEVELOPMENTS - WORKING FOR PATIENTS
MEDICAL AUDIT IN THE FAMILY PRACTITIONER SERVICES

**The guidance in this circular will be cancelled and deleted from the current communication index on 18 June 1994 unless notified separately.**

## SUMMARY

**This circular provides guidance to Family Practitioner Committees (FPCs), and their successor authorities, on the arrangements necessary to establish a framework by April 1991 that will enable all general medical practitioners to participate in medical audit procedures. It is primarily concerned with the organisational structure within which audit should be undertaken rather than the nature of the process which may differ from place to place and evolve as experience is gained. Guidance on good practice will be issued separately once results are available from pilot projects that have already been established.**

## ACTION

FPCs should:-

i. bring this circular to the attention of all general medical practitioners.

ii. proceed, in co-operation with the Local Medical Committee, to establish as soon as practicable and at the latest by April 1991, a Medical Audit Advisory Group to direct, co-ordinate and monitor medical audit activities within all general medical practices in their area.

iii. ensure that the Medical Audit Advisory Group makes appropriate links with those responsible for medical audit in the Hospital and Community Health Services, in order that plans are made to audit services bridging hospital and community health service and primary health care.

## BACKGROUND

1. The systematic review of patient care is a key component of good medical practice. The profession is agreed that there is a need for all doctors to be committed to medical audit to maintain and improve standards of practice and medical care. Audit will be professionally led. The strong educational component in medical audit is described in the recent report by the Standing Committee on Postgraduate Medical Education (SCOPME), which stresses the need for linkage with educational bodies.

2. An effective programme of audit will help to provide the necessary reassurance to patients, doctors, and managers that the highest quality of service is being sought within available resources.

3. FPCs have a responsibility to oversee the quality of services provided. In order to do this they will require sufficient information to be satisfied about the audit policies followed in their areas. FPCs will be accountable, subject to legislation, to Regional Health Authorities for the proper operation of their medical audit systems.

4. FPCs will need mechanisms, independent of the medical audit system, to consider wider issues of quality and ensure that contractual obligations are fulfilled.

**MEMBERSHIP OF MAAGS**

5. A Medical Audit Advisory Group (MAAG) should be established by every Family Practitioner Committee which will be responsible for the appointment of members. The precise size and composition of the group should be determined locally. The existence of flexibility is essential, not least because of the varying size of FPCs. Normally there should be no more than 12 members who are medically qualified. From amongst them the Chairman will be elected. The FPC should invite nominations from the Local Medical Committee and the local Faculty of the Royal College of General Practitioners. The FPC may itself propose members and should seek to agree the membership with the Local Medical Committee to ensure that the MAAG commands the confidence of both the FPC and the profession locally. The MAAG must include doctors with recognised expertise in and experience of medical audit. It is to be expected that the majority of members will be principals on the list of the relevant FPC, some of whom may be Regional or Associate Advisers in General Practice, academic staff of the Department of General Practice in a local medical school or have a local educational function.

6. The FPC should ensure that the membership of the group includes a clinical or service department consultant associated with medical audit activities in the local hospital services and where possible a public health physician. Because of the relationship between primary and secondary care, links should be fostered between doctors working in hospital and in public health medicine and their colleagues working in general practice.

7. Systematic audit will frequently involve activities of other members of the primary health care team, for example community nursing staff and practice nurses. With the consent of the FPC, the MAAG will be able to co-opt members of other disciplines, on a regular basis or when consideration is being given to activities which involve their services or when it would benefit from their expertise.

**ACCOUNTABILITY OF MAAGs**

8. The MAAG will be accountable to the FPC for:-

a. the institution of regular and systematic medical audit in which all practitioners take part, perhaps facilitated by the existence of local groups. The objective is the participation of all practices by April 1992.

b. adequate procedures to ensure that reports are cast in such a form as to ensure that individual patients and doctors cannot be identified from them.

c. establishing appropriate mechanisms to ensure that problems revealed through audit are solved and that the profession plays a full part in this. Educational approaches to remedy problems revealed by medical audit are discussed in the SCOPME Report.

d. providing the FPC with a regular report on the general results of the audit programme.

**AUDIT TEAMS**

9. The MAAG will appoint a team or teams responsible to the group for assisting practices in the development of medical audit. Each team will consist normally of two to four general practitioners knowledgeable in medical audit. Activity as a member of the MAAG or as a member of an audit team should be regarded as qualifying for FPC discretion in respect of availability to patients over four days of the week. At least one of the members of each audit team should be a member of the MAAG. The duties of the teams will include reporting to the MAAG on the system of audit in each practice.

## RESOURCES

10. Resources have been made available to FPCs for the provision of regular meetings, to support an adequate programme of practice visits and to provide adequate professional, clerical and secretarial time to enable the MAAG and its audit team(s) to carry out their responsibilities. Joint discussions should be held between the Chairman of the MAAG and the FPC General Manager to agree the programme and scale of medical audit activity. An estimate should be prepared for consideration by the FPC of the resources required to recompense doctors for the time spent on MAAG work away from their professional duties; and for support staff, information technology and finance to underpin the agreed programme. Resources made available to the MAAG will be subject to the financial control and audit procedures applicable to public expenditure more generally.

## CONFIDENTIALITY AND REPORTING

11. MAAGs will be required to keep records of the problems they identify and the actions they take to remedy unsatisfactory situations. These records, containing as they may details about identifiable doctors and their cases, must be regarded as confidential to the MAAG. In reporting to other bodies it is for the group to satisfy itself that confidentiality is maintained. While the commitment to report in general terms to the FPC is mandatory the group may also inform other bodies which it considers have an interest in its findings, for instance those responsible for service provision and postgraduate education. All reports should be cast in such a form as to ensure that individual patients and their doctors cannot be identified from them.

## EDUCATION AND TRAINING

12. Each general practitioner should have the opportunity to gain appropriate education and experience. The ready availability of training courses in medical audit will therefore be essential and MAAGs will need to discuss this with educational bodies within their region. Attendance at such recognised courses will rank for Postgraduate Education Allowance purposes. MAAGs will need to agree a local policy to ensure that appropriate educational opportunities are available to remedy deficiences revealed by audit.

## ANALYSIS OF MEDICAL AUDIT RESULTS

13. The MAAG will discuss with the FPC the data required to facilitate audit. Some will be generated at FPC level and some will be required from District or Regional Health Authorities. The importance of the availability of accurate valid data has been stressed by the Standing Medical Advisory Committee. Access to practice reports may be helpful to the MAAG and its team(s).

14. MAAGs will wish to analyse medical audit results and discuss them with Local Medical Committees and with the general medical practitioners to ensure changes in professional practice when these are required. MAAGs will need to include evaluation of the audit exercise itself in the arrangements made for audit and report on this to the FPC.

## PATIENTS' VIEWS

15. The views of patients and their degree of satisfaction with the general medical services may provide an indication of potential problems. The FPC's own assessments of consumer satisfaction could provide useful information to the MAAG. MAAGs should ensure that patients' views are taken into account as ultimately it is the interests of patients which are central to the process of medical audit.

**From:**

**MED-H (Primary Care Services)**
**Portland Court**
**Great Portland Street**
**LONDON**
**W1N 5TB**

**Tel: 071-872-9302**

**Further copies of this circular may be obtained from DoH Store, Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancs OL10 2PZ, quoting code and serial number appearing at top right hand corner.**

*Quality in Health Care* 1993;2:232–238

# Developing role of medical audit advisory groups

Charlotte Humphrey, Diane Berrow

**Abstract**

***Objectives*—To investigate the approaches to audit of different medical audit advisory groups (MAAGs) and to consider the implications for evaluation of their activities and their developing role in the light of new priorities for clinical audit.**

***Design*—Qualitative study based on semi-structured interviews.**

***Setting*—15 family health services authority (FHSA) districts in two English health regions.**

***Subjects*—MAAG chairpersons and support staff and FHSA general managers and medical advisers in each district, totalling 68 subjects.**

***Main measures*—Structures and activities of MAAGs; perceptions of the MAAG's role and its achievements compared with the initial brief in a health circular in 1990.**

***Results*—The approaches of different MAAGs varied considerably: some concentrated on promoting audit and others were involved in a wider range of development activities. MAAGs assessed their progress in various different ways. The importance of collaborative working was recognised, but few interface audit projects had been undertaken. MAAGs had little contact with other quality assurance activities in the FHSA, and FHSA involvement in the MAAG strategy was variable, although MAAGs were taking steps to improve communication with the FHSA.**

***Conclusions*—Major differences exist in the approaches taken by MAAGs and the roles they fulfil, which will make evaluation of their effectiveness a complex task. Already MAAGs are responding to changing expectations about audit and pressure for closer links with management.**

(*Quality in Health Care* 1993;2:232–238)

## Introduction

The 1989 white paper *Working for Patients* introduced medical audit as a central feature of the NHS reforms.[1] In primary care, guidance was issued requiring each family health services authority (FHSA) to set up a medical audit advisory group (MAAG), whose function would be to direct, coordinate, and monitor medical audit activities in its area.[2] MAAGs were to be medically led, most of their members being local general practitioner (GP) principals, but they would be accountable to the FHSA for carrying out their work (box).

**Accountabilities of MAAGs to FHSAs**[2]

- Instituting regular and systematic medical audit in which all practitioners take part
- Establishing procedures to ensure confidentiality for individual doctors and patients
- Establishing appropriate mechanisms to ensure that problems disclosed through audit are solved
- Providing a regular report on the general results of the audit programme

Since 1989 thinking has changed about the nature and role of professional audit in the NHS. The Department of Health's recent policy statement on clinical audit[3] exemplifies the new perspective. Medical audit is expected to give way to clinical audit, with audit becoming largely multiprofessional and spanning all aspects and sectors of care. Audit remains a professional activity, but there is increased emphasis on the influence of purchasers of health care, health service managers, and patients on the audit programme. In the light of the new priorities the department has emphasised the need to review the progress of the MAAG initiative along with that of the other audit programmes. As FHSAs move more into the role of purchasers and have to make difficult decisions about service priorities they are also increasingly concerned to know whether they are obtaining value for money from their MAAGs.[4] Thus there is a desire both nationally and locally for an analysis of what the MAAGs have been doing.

MAAGs are new bodies with a new task. They have no precedent to work with, and no established historical relationship with, other agencies in primary care. In these circumstances it is hardly surprising that the variety of approaches adopted by different MAAGs has been noted as one of their most striking features.[5] We report a qualitative study which set out to explore the nature and extent of this variation. The first aim was to find out what MAAGs were doing and how those people most directly involved perceived their tasks and achievements. By obtaining views of each study MAAG from various professional and managerial perspectives we sought to explore the degree of consensus about its role and to identify areas of disagreement. Further aims were to find out what mechanisms the MAAGs were using to measure their progress in promoting audit and to consider the implications of our findings for evaluating MAAGs themselves.

**Department of Public Health and Primary Care, Royal Free Hospital School of Medicine, London NW3 2PF**
Charlotte Humphrey, lecturer in medical sociology
Diane Berrow, research assistant

Correspondence to:
Ms Humphrey

Accepted for publication
5 November 1993

**Variable characteristics**

*Geography/population*
Large/small district
Rural/urban population
Affluent/deprived population

*General practice characteristics*
High/low proportions of singlehanded practices, training practices, and GP fundholders
Presence/absence of a local academic department of general practice
High/low profile local medical committee

*Health service characteristics*
Financially "losing"/"gaining" FHSA
Merged/separate FHSA/DHA
Overlapping/coterminous FHSA/DHA boundaries
One/several local hospitals

## Subjects and methods

Since our purpose was to explore variety rather than to establish frequencies we were more concerned to ensure coverage of a wide range of different approaches than to obtain a statistically representative sample. On these grounds we chose to study all 15 MAAGs in two English regions instead of sampling randomly from the 90 MAAGs in England as a whole. From preliminary discussions with staff in the two regions selected we were able to ascertain that the regions contained a range of districts with a wide variety of contrasting characteristics which seemed likely to influence the work of the MAAG (box).

Our initial intention was to seek interviews with the MAAG chairperson, MAAG support staff (clinical or lay), FHSA general manager, and FHSA medical adviser in each district. Names were obtained and responsibilities confirmed by telephoning the FHSA. In places where we learnt that the medical adviser had no contact with the MAAG, where structures varied, or where responsibilities had recently changed hands we followed local advice about whom to approach. We wrote to all individual subjects thus identified, asking them to agree to a confidential interview. When jobs were divided between a number of part time staff we asked to speak to one of the group or several together in the same interview.

We devised a semistructured interview schedule which we piloted with FHSA and MAAG staff in a district outside the study regions. The topics (box) were developed in consultation with an advisory group whose membership reflected the different interest groups included in the study. We used this interview schedule with all participants. When necessary during the interviews respondents were asked to clarify any differences between their personal views, those of others involved with the MAAG, and agreed MAAG strategies.

The interviews, which took one to two hours to complete, were recorded on audiotape and subsequently transcribed. Interview data were supplemented with additional information from all the MAAGs' annual reports and other relevant documents, where they were available. The data were analysed according to several themes selected on three different grounds: some were identified within the original brief for MAAGs; some have become relevant in the light of the more recent focus on clinical audit; and some emerged as important to understanding the work of the MAAGs during the interviews.

In this paper we draw on our findings to show how the MAAGs in our study had developed in different ways and how they viewed their progress in getting audit established. We consider how far they had taken on board changing views about the importance of multidisciplinary and interface audit, links with wider quality management, and management involvement in the audit agenda. Finally, we briefly discuss different criteria which might be used to evaluate the work of the MAAGs and consider the implications of our findings for any such assessments.

**Interview topics and examples of subsidiary items of inquiry**

| *Topic* | *Example of subsidiary item* |
|---|---|
| Setting up of MAAG | Extent of FHSA involvement in deciding constitution |
| Membership of MAAG | Roles and responsibilities of different members |
| Group functioning | Communication within group |
| Financing | Adequacy and conditions of funding |
| Relationships with others | Nature of FHSA-MAAG contact |
| Aims and objectives | Extent to which measurable objectives set |
| Activities and methods used | Most and least important activities of the MAAG |
| Measurement of practice audit activity | Nature of data collected |
| MAAG self evaluation | Perceived failures and achievements |
| FHSA's perceptions of MAAG | Criteria for assessment |
| Future | Likely lifespan of the MAAG |

## Results

Everyone approached agreed to be interviewed. In total we interviewed 68 people during the winter of 1992–3 (table 1). Two of the FHSA general managers and eight of the medical advisers interviewed were also MAAG members.

The titles, grades, and responsibilities of support staff varied considerably between MAAGs; here we refer to them generically as MAAG staff. In areas where views varied significantly between different categories of respondents we make this clear; where a reasonable consensus of opinion was found we have not distinguished between opinions. Respondents frequently referred to the MAAG as a single entity possessed of its own attitudes and perceptions; where it seems appropriate we have adopted this usage.

*Table 1 Subjects interviewed, by category, in 15 MAAGs in England*

| | MAAG | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *A* | *B* | *C* | *D* | *E* | *F* | *G* | *H* | *I* | *J* | *K* | *L* | *M* | *N* | *O* | |
| FHSA: | | | | | | | | | | | | | | | | |
| General manager | + | + | – | – | 2+ | + | + | + | + | + | + | + | + | + | + | 14 |
| Chief executive | – | – | + | + | – | – | – | – | + | – | – | + | – | – | – | 4 |
| Medical adviser | + | 1/3* | 2+ | + | + | –† | + | + | –† | + | – | + | + | 2/2* | –† | 13 |
| Other directorate | –† | –† | –† | –† | –† | + | –† | –† | + | –† | + | –† | –† | –† | –† | 3 |
| MAAG: | | | | | | | | | | | | | | | | |
| Chairperson | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | 15 |
| GP facilitator | – | – | – | 1/7* | + | – | – | – | – | + | – | – | – | 1/4* | – | 4 |
| Lay support staff | + | + | + | – | – | + | + | + | + | – | 4/4* | 2/2* | + | – | + | 15 |
| Total | | | | | | | | | | | | | | | | 68 |

+ Postholder interviewed.
2+ Two people interviewed (old and new incumbents).
– Non-existent/not in post.
*Number interviewed/total number for part time postholders.
†Not involved with MAAG.

HOW MAAGS HAVE DEVELOPED

The MAAG circular was primarily concerned with the organisational structure within which audit should be undertaken, rather than the nature of the audit process.[2] The original guidelines deliberately left room for local interpretation, on the assumption that approaches would differ from place to place and evolve as experience was gained.

The MAAGs in our study had conformed fairly closely to the original recommendations, as far as they went. All were numerically dominated by GPs (table 2); however, 12 of the 15 had extended their membership to include at least one FHSA representative. They were all heavily involved in providing training, support, and facilitation for their constituent practices, with a variety of different approaches; all had some links with the wider medical education system, all had developed effective methods of protecting confidentiality, and all reported regularly on their activities to the FHSA. But within these commonalities there were important differences between styles and activities reflecting the substantial room for manoeuvre within the original guidelines and the impact of widely differing local circumstances on the nature of the task faced by the MAAGs and the shape of the local response. For example, the MAAGs varied in how they perceived their role in relation to management, some seeking to provide a "buffer" between local general practice and the FHSA, others serving as a "bridge"; how they defined their function, some choosing a narrowly defined focus on audit, others assisting practices to meet a wide range of developmental needs; and how proactive they were in setting the local agenda for audit. The FHSA managers likewise differed in their perceptions of the MAAG's role, some regarding it as confined to providing audit support to general practice, others as a potential source of professional advice to the health authority across a wide range of service issues. They varied in how much importance they attached to the MAAG and what they committed to it in office support or additional funds beyond the basic budget allocation. Almost half the MAAGs had access to funding from other FHSA budget areas to help support audit. As a result of such differences the problems facing the MAAGs and their criteria for measuring success were also very variable among districts.

From our findings we constructed three models of MAAGs (box), whose characteristics were chosen, not for their particular dominance – no dominant combinations could be identified – but to illustrate the complexity of the variation. Our sample contained 15 MAAGs, each of which was unique in important ways; presumably in England as a whole there are 90 different versions. The extent of these differences limits the observations that can be made about the MAAGs as a homogeneous group.

*Table 2 Comparison of guidelines for membership and findings for 15 study MAAGs*

| *Guidelines* | *Study MAAGs* |
|---|---|
| Precise size to be determined locally. Normally "No more than 12 members who are medically qualified" | Range 7–15 medically qualified members |
| Majority of members to be local GP principals | Range 6–12 GPs |
| One hospital consultant | ≥1 Consultant (14 MAAGs) |
| One public health doctor | ≥1 Public health doctor (13 MAAGs) |
| Other health professionals might be co-opted | Nurse member (1 MAAG) |
| No mention of lay representation | Lay member (1 MAAG) |
| No mention of FHSA representation | FHSA general manager* (2 MAAGs)<br>FHSA medical advisers (8 MAAGs)<br>Other FHSA representation (2 MAAGs) |
| MAAG might employ GP facilitators | GP facilitators (4 MAAGs) |
| No mention of lay support staff | Lay support staff (11 MAAGs) |

*In addition, two general managers attended MAAG meetings as observers.

ESTABLISHING AUDIT

The first and main task for which the MAAGs were accountable in the circular was "the institution of regular and systematic medical audit in which all practitioners take part."[2]

All the MAAGs in our study had made efforts to evaluate their progress in audit and were becoming more systematic and advanced in their methods of categorising practice audit activity. Many had developed their own systems of assessment, others were using adapted versions of a model developed by the Oxford MAAG.[6] However, many MAAGs still had incomplete information about the audit activity in their practices, especially those that were unwilling to press their practices for details, those whose strategies did not entail regular or comprehensive practice visits, and those that had adopted a decentralised model of patch based working. MAAG staff also commented on the difficulty of keeping their information up to date and ensuring that practice visitors filled out assessment forms consistently. Therefore, most staff had doubts about the accuracy and validity of their own data. These problems apart, no consistency existed among the MAAGs in the information recorded about practice activity. It would not be possible, therefore, to produce an accurate aggregate measure of the degree of progress towards the objectives.

Nevertheless, all the people we interviewed from MAAGs and most FHSA respondents felt that progress was being made: there was general confidence that more practices were doing audit; the range of practice team members involved had widened; the topics

### Contrasting models of MAAGs

*MAAG A*

*Setting:* Large suburban district with a minority inner city population. Well established teaching practices in affluent areas and struggling singlehanded practices. Financially "losing" FHSA.

*Membership:* Based on shadow audit group set up by local medical committee. Commitment to including "normal" GPs. No FHSA presence on MAAG.

*Siting and support:* Administrative assistant based in MAAG member's practice.

*Finance:* £80 000 basic budget allocation from FHSA.

*Philosophy:* Non-directive, led by local GPs' interests. Willing to advise practices on wide range of professional issues. Not keen to provide practical help in areas of FHSA responsibility.

*Strategy:* Highly devolved patch based support led by GP facilitators.

*Perceived success:* Developing the trust and interest of previously sceptical local general practice.

*Pressing issues for MAAG:* Responding to diverse needs of local practices; maintaining independence from FHSA.

*Pressing issues for FHSA:* Improved communication with MAAG over its strategy; seeking evidence of value for money.

*MAAG B*

*Setting:* Medium sized, city based district. Strong academic department of primary care. Single central hospital. Coterminous FHSA/DHA boundaries.

*Membership:* Set up by general manager in consultation with academic GPs. High profile academic leadership with commitment to excellence. General manager is observer at MAAG meetings.

*Siting and support:* Research coordinator based in academic department and several audit assistants.

*Finance:* £60 000 basic budget allocation from FHSA; £45 000 over two years from externally funded projects.

*Philosophy:* Strong commitment to educational leadership. Keen to help practices with audit but not wider development issues.

*Strategy:* Organises districtwide projects on topics selected for their value in teaching about audit. Lay support staff provide practices with technical help and advice in writing proposals for funding.

*Perceived success:* Obtaining substantial external funding for projects, several publications, and a national reputation for rigorous audit.

*Pressing issues for MAAG:* Maintaining project funding and coordinating MAAG funding from multiple sources.

*Pressing issues for FHSA:* Keeping MAAG down to earth and focused on practical local issues rather than research projects.

*MAAG C*

*Setting:* Small urban/rural district. FHSA/district health authority recently merged.

*Membership:* Set up by FHSA medical adviser with public health background. Members chosen for enthusiasm and technical expertise. Medical adviser sits on MAAG.

*Siting and support:* Audit facilitator based in FHSA.

*Finance:* £45 000 budget allocation from FHSA. Free accommodation and office support. Access to GMS and FHSA "slippage" monies for practice support on an ad hoc basis.

*Philosophy:* Pragmatic commitment to improving services by whatever means available.

*Strategy:* Mixture of MAAG initiated audit projects addressing local priorities; computer based group audits and facilitation of local practice development (help with age-sex registers, teamworking, etc).

*Perceived success:* Working with FHSA to develop practice information systems and compatibility of computer systems for audit.

*Pressing issues for MAAG:* Fear of neglect of audit by the new joint health authority with its wider agenda.

*Pressing issues for health authority:* Developing multidisciplinary collaboration over a wide range of quality issues; identifying opportunities for transfer of resources to primary care.

audited were becoming more appropriate; audit skills had improved; and interest in audit had increased and fear had diminished. Some MAAGs could document these changes in great detail with evidence from their records; in others the assessment depended on a wide variety of indicators such as comments from practices, attendance at meetings, requests for MAAG help, etc. Several of the MAAG staff we interviewed, however, questioned the extent to which the MAAG could take the credit for these developments. Some felt that, in part at least, they were observing and documenting changes that would have happened anyway.

At the same time the MAAG respondents clearly appreciated where the MAAG's limits lay. All knew of practices that were not auditing and seemed unlikely to start. Some acknowledged that they had given up on a minority of the most resistant practices (often with the tacit agreement of the FHSA), believing their efforts were better placed where they were more likely to be successful. Among the practices that were doing audit, all the MAAGs were aware of instances in which one keen partner or a member of the practice staff was carrying the audit brief for the practice as a whole. The direct involvement of all practitioners, as opposed to practices, was seen by most respondents as a distant or unrealistic objective.

In the winter of 1992–3 most of the MAAGs in the study were still fully engaged in teaching about audit and getting practices started. Encouraging practices to move beyond data collection to complete the audit cycle was recognised to be the next major task and in many ways the acid test of the MAAG's worth. One MAAG chairperson spoke for many when he acknowledged that much of the current activity was not useful as it stood. "If it stays like this," he said, "we may well look back in a few years' time and say the whole thing was a failure."

The MAAG respondents also recognised the difficulties of assessing and demonstrating effective change, even supposing it could be achieved. One problem was that they did not necessarily know where changes had occurred since their commitment to confidentiality precluded access to audit results unless these were volunteered by the practice. A further problem was that, even where beneficial change was known to have taken place, it could not necessarily be acknowledged publicly without compromising the privacy of the practice. These constraints aside, beneficial effects on patient health are notoriously difficult to identify in primary care. Most MAAGs therefore relied on interim indicators of effectiveness such as changes in practice behaviour. On this basis, and using their informal knowledge of the practices, most MAAG staff we spoke to were able to produce a list of examples of beneficial change. However, there was an awareness that the changes were not always achieved in "the right way" – that is, through completing the audit cycle.

### INTERFACE AUDIT AND MULTIDISCIPLINARY WORKING

The original circular required MAAGs to establish links with public health medicine and consultants associated with hospital medical audit with a view to auditing services bridging hospital and community health services and primary care. Within primary care co-option of other team members was suggested. Nevertheless, medical audit among GPs was clearly predicted to be the major focus of activity.

The study MAAGs had their prescribed complement of hospital and public health consultants, but these members were of varying importance in the group. A few members were strongly engaged with the MAAG, others had only peripheral involvement and rarely turned up to meetings. Relatively few interface audit projects had been undertaken. Those that flourished were usually large scale projects that had obtained additional separate funding. The initiative for such projects tended to come from either one committed individual member of the MAAG or a particular confluence of circumstances, such as local interest and skill in a particular subject and opportunistic links between MAAG members and hospital staff. Such projects had clearly been easier to set up in districts with fewer hospitals and simpler local referral patterns.

MAAG respondents were well aware that success in implementing audit depended on the involvement of the whole professional team. Practice staff were encouraged to participate in discussions about audit at practice visits and in educational activities organised by the MAAG. However, commitment to multidisciplinary working had not extended to having a multidisciplinary MAAG. Many of the MAAGs had discussed co-opting other primary care staff as members of the group, but with one exception they still remained entirely medical in their professional membership.

The MAAG respondents did view interface audit and collaborative working as important, but generally they saw these as goals to pursue once audit was going well among GPs. Many regarded their present GP centred approach as the obvious first step in a development model which starts with the core professional group, progresses to include the practice team, and subsequently expands to encompass the wider primary health care team and community and hospital services. On the other hand, a minority of MAAGs were already taking a more eclectic approach, seeking to tap into enthusiasm for audit wherever it was to be found. These MAAGs had learnt from experience that there was often more commitment to audit among team members other than the GPs. They were also finding that GPs themselves were interested in carrying out audit at the interface with secondary care. In part this reflected GPs' concerns about the services their patients were receiving elsewhere; many were also keen to develop new skills and extend the care they provided – for example, in shared care for chronic diseases.

### WIDER QUALITY MANAGEMENT

Initially, medical audit was seen as clearly separate from wider issues of quality, and it was anticipated that the FHSAs would develop independent mechanisms to consider quality. Since then they have become involved with various quality initiatives including the patients' charter, total quality management projects, and British Standard 5750.

Most MAAGs in our study had no links with other quality initiatives in the FHSAs and did not forsee any. In a few cases, where the MAAG office was based in the FHSA, informal contact between MAAG staff and members of the quality assurance directorate had led to joint working on specific projects. Some of the MAAG staff involved in such collaborations, however, felt uneasy about the propriety of this association.

Formal quality assurance initiatives apart, many MAAGs had expanded their own brief to encompass several wider quality issues. For example, they were using their growing experience and knowledge about local resources to provide a significant amount of informal help to individual practices with various personal, clinical, or organisational problems often only indirectly to do with audit. In this respect most of the MAAG respondents acknowledged a support function far wider than their official role in promoting audit. Some felt this was an undesirable expansion which distracted energy and attention from the MAAG's proper purpose and led to a dangerous blurring of responsibilities between MAAG and FHSA. In some districts FHSA staff shared this view and accepted the continuing need for a limited, professionally led focus exclusively on audit and were successfully using other routes to involve professionals in their service development activities. In others MAAG respondents were interested in moving cautiously towards a role as a professional arm of the FHSA, offering advice on a wide range of practice and service development issues. Several of the FHSA managers and medical advisers were keen to suggest possible areas of collaboration with the MAAG (box). There

**Suggested service development roles for MAAGs**

Providing advice to FHSAs in:

- Evaluating changes in service provision
- Identifying opportunities for service innovation
- Identifying needs
- Evaluating demands
- Developing acceptable systems of assessment
- Developing standards
- Investigating local problems
- Promoting local strategies
- Developing other quality initiatives

was no consistent relation within districts between the views of the MAAG and FHSA on the role of the MAAG.

MANAGEMENT INVOLVEMENT

The original brief proposed joint discussions between MAAG chairpersons and FHSA general managers to agree the programme and scale of medical audit activity,[2] though by implication this was more concerned with setting the budget than agreeing the content of the MAAG's work. There was no mention of FHSA representation on the MAAG, although the FHSA had the option of suggesting members.

In 13 of the 15 study MAAGs, FHSA staff regularly attended meetings, some only as observers, but most with full membership status. Despite this presence management involvement in the MAAG's strategy was very variable. Several of the medical advisers were involved with the MAAG in a personal capacity rather than as representatives of the FHSA, and others chose to stand back from the decision making and take a more advisory role. Some general managers had played a major part in establishing the MAAG and subsequently stepped back; others had had relatively little involvement and were still seeking to establish dialogue.

There was a strong sense of growing interest among the FHSAs in negotiating with their MAAGs to ensure that national and local priorities were taken into account in planning work. The MAAGs were aware of this pressure and many had already taken steps to improve communication with the FHSA to identify common interests and increase their understanding of each other's needs. Although not prepared to be told what to do by the FHSA, they accepted the need to justify their funding not only in terms of effectiveness but also relevance to the authority's concerns. In many cases the interests of the FHSAs, MAAGs, and their constituent practices had emerged as quite compatible, simply because all were preoccupied with the same current issues, such as the health promotion banding system and the Health of the Nation priorities. All the MAAGs were committed to respecting the right of practices and individuals to choose their own audit topics, should they wish. A few MAAGs were unwilling to offer any directive leadership at all, and these were the districts that seemed to be having the greatest difficulty in reconciling the views of MAAG and FHSA.

## Discussion

We have explored the considerable variety between the approaches of different MAAGs and also identified some features they share and discussed some of the common directions they seem to be developing. Finally we briefly consider some of the implications of our findings for assessment of the value of MAAGs.

Nationally, concern might be expected to concentrate on the MAAGs' demonstrated effectiveness in promoting audit, inasmuch as this was the purpose for which they were created. However, the range of additional functions that some of the MAAGs had successfully taken on means that an evaluation on the basis of the audit work alone would be incomplete. An important strength of the way the MAAG guidelines were formulated was the opportunity for local innovation and the resulting exploration of previously unconsidered ways of working – for example, in providing professional advice on service issues. Such local developments might be evaluated on their own account and their adaptability for use elsewhere considered.

An evaluation of the MAAG initiative would have to weigh the cumulative achievements and shortcomings of all the different models represented. Earlier we commented on the problems of aggregating evidence of the progress of MAAGs and interpreting their achievements in promoting audit. Insofar as each of the MAAGs in our study was working with different priorities in different circumstances it would be equally difficult, and arguably inappropriate, to compare their approaches with a view to saying which works best. This was certainly the view of our respondents. Although many were confident of the advantages of their own approach over those of other districts that they knew about, they all accepted that no single way of working would be applicable everywhere.

In contrast, local evaluation of any individual MAAG will inevitably be influenced by the impact and perceived appropriateness of the particular approach that it has taken. Although acknowledging the audit brief of the MAAGs, some of the FHSA managers in our study were equally (sometimes even more) interested in evidence of the MAAG's ability to help them deal with other pressing issues on their own agendas. In those study districts where the views of the FHSA and MAAG of the MAAG's role differed, the perceptions of its value tended to be equally at odds.

In conclusion, when the MAAGs were set up it was not known whether their structure was appropriate to the task or how they would work. Since then those involved with MAAGs have developed a wealth of skills and understanding about what is possible and how it can be done. The MAAGs in our study had clearly provided a focus for sustained thinking about the value and limitations of audit and its links with wider service development activities. Without this focus it seemed unlikely that local understanding and discussion of these issues would have progressed so far as it had.

The past three years have seen great changes in primary health care services and in priorities for audit. Consequently, demands on the MAAGs have also changed. The new objectives of collaboration between different services and closer links between professions and management are arguably more difficult to meet and at least as controversial as the original medical audit brief. Nevertheless, the MAAGs in our study had already begun to respond to these changing expectations and

were making progress on both fronts. Despite this evidence of flexibility most people interviewed recognised that further development might entail more fundamental modifications to the MAAGs. Although they were concerned not to leave the original business of the MAAGs unfinished, many of them were already thinking about new names and structures for taking audit forward.

We thank the MAAG and FHSA staff who participated. The study was supported by a grant from the Department of Health.

1 Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients.* London: HMSO, 1989. (Cm 555.)
2 Department of Health. *Health service developments – working for patients. Medical audit in the family practitioner services.* London: HMSO, 1990. (HC(FP) (90)8.)
3 Department of Health. *Clinical audit: meeting and improving standards in health care.* London: NHS Management Executive, 1993.
4 Wall C. Medical audit – value for money. *Audit Trends* 1993;**1**(2):43–5.
5 Spencer J. Audit in general practice: where do we go from here? *Quality in Health Care* 1993;**2**:183–8.
6 Derry J, Lawrence M, Griew K, Anderson J, Humphreys J, Pandher KS. Auditing audits: the method of Oxfordshire Medical Audit Advisory Group. *BMJ* 1991;**303**:1247–9.

# EVALUATING MEDICAL AUDIT ADVISORY GROUPS

*Charlotte Humphrey*
Director
Health Policy Evaluation Unit
Royal Free Hospital School of Medicine

I was asked a few months ago by the Department of Health to produce a report which would pull together all the data available to date from evaluative studies of medical audit advisory groups (MAAGs)[1]. The experience of writing that report raised a number of questions about evaluation which this paper sets out to explore. I shall consider, first, why and how we evaluate MAAGs and, second, what particular challenges they present for evaluation at a national or local level.

## Approaches to Evaluation

There are two quite different but equally important components of evaluation. I have called them "formal" and "pragmatic". "Formal" evaluation takes the policy as its starting point and looks at the extent to which its premises have proved to be correct. So, for example: Does audit improve patient care? Do MAAGs promote audit effectively? If they do, is the MAAG the most effective structure for facilitating improvements in patient care through audit? These are the kinds of questions that seem important at a national level. If the answers to them are equivocal, then the policy may need to be reconsidered.

The other type of evaluation, which may be more immediately important at a local level, is "pragmatic" evaluation. This involves much more open-ended questions. For example: Is the MAAG useful (whatever "useful" means)? To those who work in it, is it worth my time, my energy? To those who fund it, is it worth our money? To the practices who are expected to use it, is it worth taking any notice of? If the answers to questions such as these are equivocal, then the policy won't work, however effective audit may have been shown to be in improving patient care. For if the health authority does not fully support the MAAG, if people don't want to be members of it and practices don't read its newsletters, don't ring it for advice, don't welcome its facilitators, then audit won't get the chance to be effectively promoted by the MAAG.

## Evaluation Criteria

The criteria used for "formal" evaluation are self-evident because they are implicit in the policy. In a "formal" evaluation you will look for evidence that MAAGs promote audit effectively and that audit improves patient care. In contrast, the criteria for "pragmatic" evaluation cannot be deduced from the policy, they vary between stakeholders (practices, MAAG members,. health service managers), between districts and within districts over time. People on the ground may well be interested in the given objectives of the MAAGs, but they will also be concerned about the fit of the MAAG with other personal or organisational agendas of their own. For MAAG members it may be important whether work for the MAAG is interesting and enjoyable and how it contributes to their own personal development. The FHSA may ask how the work of the MAAG contributes to achieving the wider objectives of the authority. Practices may ask whether it offers practical help to meet their needs (which may have little to do with audit).

## Evaluation Methods

Methods of "formal" evaluation are well rehearsed and a lot of work has been done on the audit initiative in primary care[1]. Much of this has been through formal research studies at places like the Eli Lilly National Clinical Audit Centre. Many MAAGs have also developed their own methods of evaluating their work[2,3]. There has been a concentration on audit activity, looking at issues such as quality and quantity of audit, the appropriateness of the topics studied, the range of people involved, and evidence that change has been achieved. Less work has been done so far on how to measure the development of an audit culture.

The basis of "pragmatic" evaluation is completely different. It is not an explicit or systematic activity, but something which happens all the time without being thought about. Pragmatic perceptions of the value of the MAAG are based on opportunistic evidence and experience and may be influenced by demands and constraints in other areas of activity that are quite unconnected with the MAAG. Some might say that these judgements are so soft and unscientific and hard to define that they cannot be taken into account. I would argue, however, that pragmatic evaluation must be taken seriously because it has very real consequences - if the MAAG is not valued by all the stakeholders it cannot flourish.

## Development of MAAGs

Bearing these thoughts in mind, I want to look briefly at how MAAGs have developed and to

consider how these two different ways of evaluating apply in practice. Most of my material is based on a study we did last year of 15 MAAGs in two health regions, for which we interviewed 68 MAAG chairs, support staff, FHSA general managers and medical advisers[4].

There are a number of commonalities that all MAAGs share. In our study, all MAAGs were working towards the four areas of accountability specified in the original MAAG circular: all MAAGs are very busy, in one way or another, promoting audit and developing skills; all have found ways of maintaining confidentiality; all have some sort of links with continuing medical education; and all report regularly to their FHSAs.

Within these commonalities, however there are important differences between the styles and activities of different MAAGs. These reflect the substantial room for interpretation in the original guidelines (which were much more about structure than about process) and the widely differing local circumstances in which MAAGs have developed. First MAAGs work in very different districts: some are very large, some small; some rural, some urban; some have more affluent, some more deprived populations; some have complex local NHS structures involving several different DHAs and major hospitals and complicated referral patterns, others are structurally much more simple. Second, the profile of local general practice varies in terms of attitudes, experience and readiness for audit. The MAAG's approach and its room for manoeuvre is also affected by existing relationships between local practitioners and the FHSA. Third, MAAGs are working with different resources. Both the recent Birmingham MAAG survey and an earlier national survey carried out for the Department of Health show substantial variations between basic MAAG budgets in different districts[1]. This variation is not explained by district size or numbers of GP principals[5].

What has been the impact of these differences on the MAAGs? I want to describe three different examples. None of these MAAGs actually exists, but each one is based on a composite of characteristics from the MAAGs in our study.

***MAAG A*** is in a large suburban district with a minority inner city population. It has a combination of well established and struggling practices. It has two DHAs to relate to and a financially "losing" FHSA. The MAAG membership is based on a shadow audit group set up by the Local Medical Committee. It has no other source of money besides its basic budget allocation. It is willing to advise practices on a wide range of professional issues, but is not keen to offer practical help in areas of FHSA responsibility. It sees its role as a buffer between local practices and the FHSA. It has developed a highly devolved patch-based support system where GP facilitators offer assistance but do not seek to intrude on local practices. The evaluation it has done to date is based on a modified version of the method developed by the Oxford MAAG[2] but it has had problems getting records scored in a consistent way by the GP facilitators in the different patches. It has major problems in keeping its data up to date on all the practices and doesn't have much information about change achieved through audit because it hasn't systematically asked practices for this. The pressing issues for this MAAG are to respond to the diverse needs of local practices and to maintain independence from the FHSA to retain the trust with GPs which it has built up. The FHSA is doubtful about the value of audit or the MAAG and wants more information about its activities and evidence of effectiveness.

***MAAG B*** is in a medium-sized city based district with a strong academic department of primary care. It has a single central hospital and coterminous authority boundaries. The MAAG was set up by the FHSA general manger in consultation with the academic GPs. Besides its basic budget, it also has substantial funds from project grants it has managed to achieve. It is keen to help practices with audit but not with wider development issues. It sees its role as largely independent from the FHSA, with a separate educational remit. It organises district-wide projects on topics which are selected for their value in teaching about audit. Lay support staff provide practices with technical help and advice on writing proposals for funding. As far as evaluation goes, the MAAG has information about numbers of practices participating in its group audits and data from those audits. As it has no visiting programme it has no individually collected audit activity data, although it has done a couple of questionnaires. The pressing issue for this MAAG is how it will maintain its project funding and the staff funded by those projects in the future when regional money may no longer be available. The FHSA is fully persuaded of the value of audit and is very proud of the MAAG's high national profile, but would like to bring the MAAG down to earth. It wants more audit that is evidently locally relevant.

***MAAG C*** is in a small urban district with rural surroundings. Its FHSA and DHA have recently joined forces. The MAAG was set up mainly by the FHSA medical adviser, who has a background in public health. As well as its basic budget allocation, it has free accommodation within the

FHSA and substantial access to FHSA "slippage" monies. The MAAG has a pragmatic commitment to improving patient care by any means available. Its strategy involves a mixture of MAAG initiated audit projects addressing local priorities, computer based group audits and facilitation of local practice development (help with age-sex registers, computerisation, teamworking etc). Its evaluation data is mainly documentation of the use made of grants given to practices and support staff records of the help they have offered to practices and the improvements achieved. It also has some data from its group audits. The pressing issue for this MAAG is fear of the neglect of audit by the new joint health authority which now has a much wider remit and is preoccupied with reallocating resources to primary care. The FHSA is happy with the MAAG. It is not much interested in audit for its own sake, but has found the MAAG useful in a wide variety of ways.

## Evaluating MAAGs

What do the differences between these three exemplar MAAGs demonstrate about the problems of evaluating the MAAG initiative? First, there are major difficulties in any attempt to compare MAAGs, because like is not being compared with like. Second, there are problems in attempting to identify which approaches work best, because something that works well in one district might be quite inappropriate in another. Third it is difficult to aggregate the achievements of all MAAGs and evaluate them collectively, because they all collect data on different things in different ways with different degrees of rigour.

The way in which MAAGs have developed poses some important additional challenges for evaluation. The first is to take on board the enormous diversification within audit. I have not commented on what MAAGs are doing in relation to the primary/secondary interface, but most are beginning to develop in those areas. Most of the data we have so far on what MAAGs are doing is based on what is going on within individual practices. We don't have methods of evaluating inter-practice collaboration. We have data from individual district-wide audits, but no adequate way of assessing activity at a district level except by counting up the projects. Second, we need to think about how to evaluate the MAAGs that have already moved well beyond facilitating audit into professional and service development. The very existence of the MAAGs and their commitment to working with all practices has provided a focus for local knowledge and a general professional resource for local practices which didn't exist in the same way before. The MAAG also offers a focus for researching audit methods appropriate to local circumstances and developing a cadre of local professionals with skills in managing groups, facilitating and developing policies within primary care. No evaluation of MAAGs that I know of has taken account of any of these dimensions although in many places they are an increasingly important component of MAAG activity.

The biggest challenge of all, however, is to address the complex relationship between evidence of effectiveness of audit and local perceptions of the

value of the MAAG. Let me return to my three examples: the FHSA in District A was uncomfortable about the MAAG for a number of reasons, partly to do with professional boundaries and feeling excluded and wanting information. It was sceptical about the value of the MAAG and audit, but it might potentially be won over by evidence of effectiveness. In District B, the FHSA was already fully persuaded of the value of audit (perhaps even over confident in its power). Nevertheless, it was not entirely happy with the MAAG, because it was concerned to bend it more to its own purposes. The FHSA wanted the MAAG to be useful to the authority, as opposed to just doing useful audit. In District C, the FHSA was relatively unconcerned about the effectiveness of audit. It had no need for further evidence, because it had no doubts about the value of the MAAG for general professional assistance in supporting and developing practices.

While "formal" evaluation continues rightly, to focus on the effectiveness of the MAAGs in achieving the original policy objectives, it is clear from these examples that the outcome of that evaluation is only part of the picture at local level. In some places, evidence of effectiveness may hardly be seen as relevant. What we need to develop, therefore, is a broader approach to evaluating the MAAGs *in situ* not as a policy in isolation, but as living changing organisms in the complex and shifting environments in which they work. Any suggestions as to how to do that would be most welcome.

## References


1. *Humphrey C, Berrow D. Medical Audit in Primary Care. A Collation of Evaluative Projects 1991-1993. NHSME 1993.*
2. *Derry J, Lawrence M, Griew K, Anderson J, Humphreys J, Pandher KS. Auditing Audits: The Method of Oxfordshire Medical Audit Advisory Group. British Medical Journal 1991;303:1247-9.*
3. *Kirklees MAAG. Supplement to Kirklees Audit Gazette 8 June 1993.*
4. *Humphrey C, Berrow D. Developing role of medical audit advisory groups. Quality in Health Care 1993;2:232-238.*
5. *Griew K, Mortlock M. A study of MAAG organisation and Function. Audit Trends 1993; 1(3):89-93.*



This paper is based on a presentation to the Second National MAAG Conference, Norwich, February 1994.

*Quality in Health Care* 1995;4:166–173

# Promoting audit in primary care: roles and relationships of medical audit advisory groups and their managers

Charlotte Humphrey, Diane Berrow

**Abstract**

***Objectives*—To investigate perceptions of family health service authorities and medical audit advisory groups of advisory groups' involvement in clinical audit and wider quality issues; communication with the authorities; and manager satisfaction.**

***Design*—National postal questionnaire survey in 1994.**

***Setting*—All family health services authority districts in England and Wales.**

***Subjects*—Chief executives or other responsible authority officers and advisory group chairpersons in each district.**

***Main measures*—Priorities of advisory group and authority for audit; involvement of advisory group in wider quality issues; communication of information to, and contacts with, the authority and its involvement in planning the future work of the advisory group; and authorities' satisfaction.**

***Results*—Both groups' views about audit were similar and broadly consistent with current policy. Advisory group involvement in wider quality issues was extensive, and the majority of both groups thought this appropriate. Much of the information about their activities collected by advisory groups was not passed on to the authority. The most frequent contact between the two groups was the advisory group's annual report, but formal personal contact was the most valued. Most authority respondents thought their views had been recognised in the advisory group's planning of future work; only a small minority were not satisfied with their advisory groups. Dissatisfied respondents received less information from their advisory groups, had less contact with them, and thought they had less input into their plans. There was some evidence that advisory groups in the "dissatisfied districts" were less involved in clinical audit and with their authorities in wider quality issues.**

***Conclusions*—Most advisory groups are developing their activities in clinical audit and have expanded their scope of work. The quality and availability of information about progress with audit is a cause for concern to both groups.**

(*Quality in Health Care* 1995;4:166–173)

Keywords: medical audit advisory group, family health services authorities, primary care audit

Medical audit advisory groups were set up in 1990 to facilitate the development of audit in general practice. At that time the focus was on unidisciplinary medical audit, the choice of audit topics was regarded as a matter for the participating doctors, and health service managers had minimal involvement in the activities of the advisory groups. Since then important changes have occurred in national audit policy, including a shift of emphasis towards multidisciplinary clinical audit, an assumption that audit should be directed, at least partly at local and national health service priorities, and an expectation of increased management participation in defining audit strategy and using its findings (table 1).

*Table 1 Developments in primary care audit policy*[1–5]

| | *Policy document* | *Key points* |
|---|---|---|
| 1989 | *Working for Patients*[1] (government white paper) | Medical audit introduced as a central feature of NHS policy |
| 1990 | *Medical audit in the family practitioner services* (HC(FP)(90)8)[2] (health circular) | Each family health services authority to set up a medical audit advisory group to facilitate the development of audit in general practice. Advisory group members to be mainly general practitioners, with representation from public health and hospital medicine. Audit to be professionally led. Advisory group to report regularly to family health services authority on the general results of the audit programme. No formal expectation of family health services authority input into advisory group strategy or membership of the group |
| 1993 | *Clinical audit: meeting and improving standards in health care*[3] (NHSME discussion document) | Shifted emphasis from uniprofessional medical audit to multiprofessional clinial audit. Audit to remain professionally led, but the management contribution to audit strategy to be enhanced |
| 1994 | *Clinical audit: 1994–5 and beyond EL(94)20*[4] (NHSME executive letter) | Guidance on the practical steps to be taken to support the development of clinical audit and recommendation of development of an agreed contract between family health services authority and advisory group |
| 1994 | *Letter from NHSME to advisory groups*[5] | Extended provisions of 1990 circular regarding arrangements for advisory groups to 31 March 1996. Emphasised need for advisory groups to encourage multidisciplinary, interpractice, and interface audit between primary and secondary care. Encouraged advisory groups to develop business plans |

**Health Policy Evaluation Unit, University Department of Public Health, Royal Free Hospital School of Medicine, London NW3 2PF**
Charlotte Humphrey, lecturer in medical sociology
Diane Berrow, research officer

Correspondence to:
Ms Humphrey

Accepted for publication
7 April 1995

**Family health services authorities***

- Responsible for services provided by general practitioners, and National Health Service dentists, pharmacists, and opticians. Receive funds from, and are accountable to, the regional health authority
- 96 family health services authorities existed in England and Wales in 1994

*Main functions*

- Administer the nationally negotiated contracts of general practitioners and National Health Service dentists, pharmacists, and opticians
- Manage cash limited budgets for general practitioner premises and practice staff
- Manage the general practitioner indicative prescribing scheme
- Maintain lists of patients registered with general practitioners
- Define the primary healthcare needs of the area (in collaboration with the district health authority) and produce plans to meet those needs
- Investigate complaints against family practitioners

*Family health services authorities will merge with district health authorities in April 1996

**Medical audit advisory groups**

- Set up in 1990 in every family health services authority district in England and Wales
- Constituencies vary in size from fewer than 20 practices to more than 350 practices

*Membership*

- Chaired by a general practitioner and include up to 12 doctors, most of whom are local general practitioners
- Most include representation from hospital medicine and public health. Some include representatives of the wider primary healthcare team and the general public

*Responsibilities*

- To institute regular, systematic medical audit in which all practitioners take part
- To establish procedures to ensure confidentiality of audit results for individual patients and doctors
- To establish appropriate mechanisms to ensure that problems disclosed through audit are solved
- To provide a regular report to the family health services authority on the general results of the audit programme

*Funding*

- Budget allocation from the family health services authority (average allocation in 1992–3 was £71 640)

*Activities*

- Most advisory groups use a combination of approaches to promote audit in their district, including individual practice visits, geographical patch work, topic groups, interpractice audits, districtwide audits, education and training, and practical help

As they have evolved advisory groups have moved beyond their original brief in several ways which reflect these changing expectations. For example, many have extended their membership to include members of the wider primary healthcare team and have developed closer links with their family health services authorities than are formally required. For their part, managers of family health services authorities have shown increasing interest in encouraging advisory groups to take account of their priorities for audit and to cooperate in wider aspects of practice development.[6] The NHS Executive encouraged advisory groups to shift the emphasis of their work towards multidisciplinary and interface audit work and to agree business plans with their family health services authorities.[5] Presently, however, all such developments are locally negotiated as no formal changes have been made to the provisions of the original circular regarding the structure, activities, and accountability of advisory groups.[2]

What will happen to advisory groups when the new unitary health authorities come into being in April 1996 and responsibilities for primary and secondary care audit are amalgamated in one organisation is not yet clear, but professional support for audit will probably continue to be required. The recently published report of the primary care working group of the Department of Health's clinical outcomes group proposed that facilitation of clinical audit in primary care should become part of a wider range of support for quality assurance and development available to practices and suggested replacing or restructuring advisory groups to reflect the arrangements required to bring these functions together.[7] The report argues against central directives on the structure of such support but favours locally developed contractual arrangements which build on the experience already gained. It calls for several models of supporting clinical audit and service development to be explored, with particular regard to their functions, accountability arrangements, and the preferences of local stakeholders. As a starting point the advisory group itself needs to be explored in these terms, so that consideration of alternatives is informed by knowledge of the nature, strengths, and limitations of what presently exists.

The aim of this study was to obtain some systematic information on how advisory groups nationally have responded to the changing needs and demands of the health service environment and how these responses are perceived by the family health services authority managers to whom advisory groups are accountable. Specific objectives were to investigate the perceptions of both groups of the commitment of advisory groups to clinical audit and their involvement with the family health services authorities in wider quality issues; to explore the nature and acceptability of arrangements for informing managers about, and involving them in, the work of their advisory groups; and to consider reasons for variations in manager satisfaction.

## Subjects and methods

We sent postal questionnaires to all family health services authorities and advisory group chairpersons in England and Wales in May 1994. The family health services authority questionnaire was intended for completion by

### Questionnaire content

Advisory group and family health services authority questionnaires contained five main subsections:

1 *Advisory group strategies for promoting audit*
For each item on a list of different aspects of audit all respondents were asked to state (*a*) whether or not the advisory group was presently promoting this aspect *and* (*b*) whether it should be a priority for the advisory group in the future (irrespective of the answer given to (*a*))

2 *Wider quality issues*
Besides their remit for audit, several other ways advisory groups might work with family health services authorities to improve quality of care have been suggested. For each item on a list of potential areas of help all respondents were asked to state (*a*) whether or not the advisory group was presently advising or helping the family health services authority in this way *and* (*b*) in areas where the advisory group was *not* presently involved, whether such involvement would be appropriate (advisory group respondents) or valuable (family health services authority respondents)

3 *Information about the advisory group's activities*
For each of a list of possible types of information advisory group respondents were asked to state (*a*) whether the advisory group collected this type of information *and* (*b*) whether or not it passed it on to the family health services authority. Family health services authority respondents were *not* asked what types of information they presently received. Instead, for each item in the list they were asked to state whether they *did* find it valuable (those receiving information) or *would* find it valuable (those not receiving information)

4 *Mechanisms for maintaining contact between advisory group and family health services authority*
For each of a list of possible forms of contact all respondents were asked to state (*a*) whether or not this form of contact applied locally *and* (*b*), if it did apply, whether it was valuable

5 *Planning future work of the advisory group*
All respondents were asked whether family health services authority views about what the advisory group should do in future had been sought by the advisory group, whether their views had been taken account of by the advisory group; and, if so, how

For each subsection in both questionnaires an open ended question asked respondents to describe any concerns or reservations.

In addition, subsections 1, 3, 4 and 5 of the family health services authority questionnaire were each followed by a question about the respondent's satisfaction with the situation. Preset response categories were: satisfied; satisfied, but with reservations; not satisfied; unsure. No question was asked about subsection 2 because this is not formally a core part of advisory group work and whether respondents would perceive this area as relevant to their advisory group could not be predicted.

the person with lead responsibility for the advisory group. These questionnaires were addressed to the chief executives or general managers. If they did not regard themselves as appropriate respondents, they were asked to provide the name and designation of the appropriate person.

As the entire populations of both respondent groups were included in the study, piloting the questionnaires with equivalent samples was not possible. Instead, draft questionnaires were tested and discussed with various people (n = 8) involved with advisory groups in other ways and modified on the basis of their comments. The final questionnaires for advisory groups and family health services authorities differed in detail but dealt with essentially the same ground. The box shows the main domains of the two questionnaires and the differences between them.

Responses to the closed questions were coded, entered on to a database and verified, and frequency data were produced. Responses from the same districts for advisory groups and family health services authorities were cross-tabulated to compare perceptions and investigate possible associations between advisory group activities and satisfaction of family health services authority respondents. The content of responses to the open ended questions were analysed by hand. Themes were identified and responses categorised by CH and DB independently; subsequent comparison of the themes showed close agreement.

## Results

### RESPONDENTS

We identified 96 family health services authorities and 98 advisory groups (in two places two advisory groups were linked to the same family health services authority) and obtained a response rate of 85(89%) for the family health services authorities and 90(92%) for the advisory groups. A completed questionnaire was received from either the advisory group or the authority in every district, and in 79 districts responses were obtained from both. Of the 85 authority questionnaires returned, 47(55%) were completed by chief executives or general managers, 15(18%) by medical advisers or directors, 9(11%) by directors of primary care development, and 14(16%) by directors of quality or strategy or directors of public health. Of the 90 advisory group questionnaires returned, 85(94%) were completed by advisory group chairs and the remainder by other members or employees. Most respondents to each questionnaire had been in post for one year or more, but 12 authority respondents and one advisory group chair had been appointed more recently.

### ADVISORY GROUP STRATEGIES FOR PROMOTING AUDIT

Respondents' views as to what the advisory group should be doing about audit were generally similar and broadly consistent with current policy (table 2). Both groups of respondents were more likely to emphasise multidisciplinary audit, interface audit between primary and secondary care, and topics of local concern, although the authority's emphasis on these was more marked. For both advisory group and authority respondents unidisciplinary audit was the category least often mentioned as a priority. Both groups singled out audit between general practice and community services for future development.

Thirty eight (45%) authority respondents volunteered concerns about the way the advisory groups' audit activities were evolving. The two main problems they identified were that these were based neither on family health services authority priorities nor on areas of more general concern in primary care and that the advisory group was not paying sufficient attention to practices that were not doing audit. Forty one (46%) advisory group respondents also expressed anxieties about the direction of advisory group audit work, but their concerns were rather different. The main themes were worry about losing their independence from the family health services authority and forfeiting the support of their general practice constituents by moving too far away from practice interests.

*Table 2 Present and future priorities for advisory groups. Figures are numbers (percentages) of respondents*

| Aspect of audit | Authority respondents (n = 85) | | Advisory group respondents (n = 90) | |
|---|---|---|---|---|
| | Present and future priorities | Future but not present priorities | Present and future priorities | Future but not present priorities |
| Focus for projects: | | | | |
| Individual practice audit | 53(62) | 2(2) | 40(44) | 2(2) |
| Interpractice audit | 25(29) | 14(16) | 36(40) | 6(7) |
| Districtwide audit | 44(52) | 9(11) | 37(41) | 6(7) |
| Professional groups involved: | | | | |
| Single discipline | 26(31) | 1(1) | 23(26) | 0(0) |
| Multidiciplinary | 52(61) | 8(9) | 45(50) | 4(4) |
| Primary/secondary care | 52(61) | 10(12) | 44(49) | 7(8) |
| General practice/community services | 28(33) | 22(26) | 35(39) | 25(28) |
| Audit topics: | | | | |
| Individual/practice interests | 38(45) | 3(4) | 38(42) | 1(1) |
| Topics of local concern | 52(61) | 10(12) | 43(48) | 4(4) |
| Topics of national concern | 32(38) | 8(9) | 39(43) | 3(3) |

*Table 3 Wider quality issues: present and potential advisory group involvement. Figures are numbers (percentages) of respondents*

| Advice or help for family health services authority* | Advisory group presently involved | | Advisory group not presently involved but such involvement would be appropriate | |
|---|---|---|---|---|
| | Advisory group respondents (n = 90) | Authority respondents (n = 85) | Advisory group respondents† | Authority respondents† |
| Evaluate changes in service provision | 28(31) | 25(29) | 31/62(50) | 32/60(53) |
| Identify opportunities for service innovation | 38(42) | 25(29) | 23/52(44) | 41/60(68) |
| Identify practice needs | 59(66) | 36(42) | 16/31(52) | 24/49(49) |
| Evaluate demands from practices | 27(30) | 11(13) | 19/63(30) | 28/74(38) |
| Develop guidelines | 63(70) | 57(67) | 13/27(48) | 18/28(64) |
| Develop quality initiatives – for example total quality management | 40(44) | 29(34) | 26/50(52) | 34/56(61) |

*Categories based on suggestions by respondents in a study in 1992–3 for possible areas of collaboration between advisory group and family health services authority.[9]
†Denominator varies owing to including only respondents whose advisory groups were not presently involved.

Forty four (52%) authority respondents were satisfied without reservation with the advisory groups' strategy for audit and most of the rest were satisfied, with reservations. Seven (8%) respondents were dissatisfied. Although this number is very small, it is worth noting that these respondents were much less likely than those who were satisfied to believe that their advisory groups were presently engaged in promoting audit across professional boundaries (four (57%) of the dissatisfied respondents as against 41(93%) of those who were satisfied), between primary and secondary care (three (43%) of the dissatisfied respondents as against 40(91%) of those who were satisfied), or between general practice and community services (two (14%) of the dissatisfied respondents as against 24(55%) of those who were satisfied). To some extent these perceptions appear to be correct, insofar as advisory group respondents in the seven "dissatisfied family health services authority" districts were also substantially less likely to state that their advisory groups were doing interface audit of any kind. However, where multidisciplinary audit was concerned, all the advisory group respondents in these districts claimed that their advisory groups were engaged in such work. The discrepancy between satisfied and dissatisfied authority respondents may be a consequence of dissatisfied respondents being less aware of what their advisory groups were doing, rather than any real difference in activity on the part of those groups.

## WIDER QUALITY ISSUES

The involvement of advisory groups with their family health services authorities in wider areas was quite extensive (table 3). In almost every category listed in the questionnaire most advisory group and authority respondents said either that their advisory group was already involved or, if it was not, thought that involvement of this sort would be appropriate. However, perceptions of the present involvement of advisory groups differed between the two groups, with advisory group respondents being consistently more likely to say that they were already participating in such work. This discrepancy may reflect different interpretations of what the advisory group was doing or lack of awareness of authority respondents of help that was being provided by the advisory group. Although interest in an expanded remit was widespread, not all advisory group respondents were keen to develop the advisory group's work in these areas and 24(27%) mentioned specific concerns about the risks of blurring the distinction between educational and contractual audit, becoming the family health services authority's "detective arm" and thereby losing the confidence of local practices.

Authority respondents were not asked directly about their satisfaction with the advisory group's activities in respect of these wider quality issues. However, there was some evidence of an association between their perceptions of the extent of advisory group activity in these categories and their satisfaction with the opportunities for family health services authority input into advisory group plans. For example, only one (7%) of the 14 authority respondents who were dissatisfied with their opportunities for input thought the advisory group was helping them in identifying practice needs compared with 28(60%) of the

*Table 4 Information collected by advisory groups and communicated to family health services authorities and what family health services authorities would find valuable. Figures are numbers (percentages) of respondents*

| *Type of information or data* | *Advisory group collecting information (n = 90)* | *Advisory group making such information available to family health services authority (n = 90)* | *Authority respondents who find or would find such information valuable (n = 85)* |
|---|---|---|---|
| Anonymised data on: | | | |
| Number of practices auditing | 88(98) | 82(91) | 76(89) |
| Number of audits per practice | 76(84) | 23(26) | 47(55) |
| Topics audited (practice based and interface) | 84(93) | 67(74) | 79(93) |
| Practice progress around audit cycle | 73(81) | 41(46) | 37(44) |
| Outcome of audit (change achieved) | 71(79) | 41(46) | 80(94) |
| Staff involved in audit | 66(73) | 35(39) | 51(60) |
| Attitudes to audit | 59(66) | 37(41) | 31(37) |
| Attitudes to the advisory group | 57(63) | 32(36) | 33(39) |
| Characteristics of non-auditing practices | 41(46) | 19(21) | 55(65) |
| Anonymised details of: | | | |
| Requests for advisory group help | 74(82) | 32(36) | 34(40) |
| Problems faced by practices in carrying out audit | 70(78) | 45(50) | 70(82) |
| Financial support given to practices | 77(86) | 60(67) | 51(60) |
| Practical help given to practices | 82(91) | 44(49) | 47(55) |
| Educational activities for general practitioners organised by advisory group | 87(97) | 72(80) | 61(72) |
| Educational activities for private health care team members | 76(84) | 64(71) | 56(66) |
| Participation in advisory group educational activities | 76(84) | 48(53) | 52(61) |
| Participant feedback on advisory group educational activities | 70(78) | 38(42) | 48(57) |

47 who were satisfied in this respect. None of the dissatisfied respondents thought the advisory group was involved in developing quality initiatives against 22(47%) of those who were satisfied. Only five (36%) of the dissatisfied respondents felt the advisory group was helping them to develop guidelines against 35(74%) of those were satisfied. Responses from the advisory groups confirmed that advisory group involvement with the family health services authority in all the categories listed in table 3 was indeed lower in the 14 "dissatisfied family health services authority" districts. However, there was also a consistent tendency for satisfied authority respondents to overestimate their advisory group's involvement in these areas and for dissatisfied authority respondents to underestimate what their advisory group was doing.

### INFORMATION AVAILABLE ABOUT ADVISORY GROUPS' ACTIVITIES

Most advisory groups collected a wide range of different types of information about their own activities and the audit activities of their constituent practices, but much of this information was not communicated to the family health services authority. For many of the categories of data (table 4) rather more authority respondents wanted information than seemed to be receiving it and in a few cases, such as audit outcomes, audit topics, and characteristics of non-auditing practices, the shortfall was substantial.

Thirty nine (46%) authority respondents and 48(53%) advisory group respondents expressed doubts about the adequacy of the information that was available about progress with audit. The main concern of the authority respondents was insufficient information from the advisory group in relation to outcomes of audit to know whether the money invested was resulting in real improvements in patient care. Some respondents also commented on the shortage of data which would show progress with audit in individual practices. For their part, advisory group respondents emphasised the limitations of the methods available for measuring or recording activity; the difficulties of obtaining robust, reliable, and appropriate information from practices; and the particular problems of measuring outcomes.

Only 31(37%) authority respondents were satisfied without reservation with the information available to them and 14(17%) were dissatisfied. For almost every category of data the dissatisfied respondents were less likely than the satisfied respondents to be receiving information from their advisory groups. They also seemed to have slightly different information requirements. For example, they were much more likely to want information on the characteristics of non-auditing practices (12(86%) dissatisfied respondents *v* 17(54%) satisfied respondents) and yet none of their advisory groups were said to be providing this information, compared with 11(35%) of the advisory groups in the "satisfied family health services authority" districts.

### MECHANISMS FOR MAINTAINING CONTACT BETWEEN ADVISORY GROUP AND FAMILY HEALTH SERVICES AUTHORITY

Respondents were asked which of a list of possible forms of contact applied in their district and which they found valuable (table 5). The discrepancy between the proportions of advisory group and authority respondents who said that family health services authority managers or staff were advisory group members seems to be attributable to confusion over the categories of manager, staff, and medical adviser and between membership of the advisory group and observer status. When the first three categories in table 5 are considered together 82% of both groups (74 advisory group and 70 authority respondents) seemed to regard the family health services authority as having a presence of one or more of these kinds within the advisory group.

Although practically all advisory groups provided their family health services authority

*Table 5 Forms of contact between advisory group and family health services authority: frequency and perceived value. Figures are numbers (percentages) of respondents*

| Form of contact | Applies in this district | | Proportion of those where it applies who find it valuable | |
|---|---|---|---|---|
| | Advisory group respondents (n = 90) | Authority respondents (n = 85) | Advisory group respondents* | Authority respondents* |
| Family health services authority manager/staff member is advisory group member | 14(16) | 28(33) | 10/14(71) | 18/28(64) |
| Family health services authority adviser is advisory group member | 49(54) | 49(58) | 30/49(61) | 32/49(65) |
| Family health services authority has observer status at advisory group meetings | 25(28) | 20(24) | 14/25(56) | 9/20(45) |
| Family health services authority receives written reports of advisory group meetings | 36(40) | 35(41) | 6/36(17) | 7/35(20) |
| Family health services authority receives advisory group annual report | 89(99) | 84(99) | 32/89(36) | 34/84(40) |
| Family health services authority manager and advisory group chair have regular meetings | 45(50) | 63(74) | 31/45(69) | 40/63(63) |
| Family health services authority manager and advisory group members/staff have informal contact | 57(63) | 68(80) | 32/57(56) | 24/68(35) |

*Denominator varies owing to including respondents who had this type of contact.

with an annual report, fewer than half of the advisory group or authority respondents identified this as valuable. In contrast, formal personal contact between advisory group and family health services authority through regular meetings or family health services authority representation within advisory group was rated highly by most of those who had these, but such contact did not occur in all districts. In addition to those forms of contact specifically asked about, some advisory group and authority respondents mentioned the benefits of regular meetings between family health services authority staff and advisory group staff and of advisory group members attending family health services authority board meetings to present and answer questions about advisory group work.

Forty five (50%) advisory group respondents and 48(57%) authority respondents said the advisory group and family health services authority had a formal agreement (usually a business plan) about what the advisory group would do in 1994–5. Most of these agreements were viewed by both parties as beneficial in clarifying objectives and helping to provide direction for the advisory group. However, some advisory group respondents were concerned about the restrictive and inflexible nature of formal agreements and the increased opportunities they provided for unwanted management intervention. In contrast, authority respondents saw the potential for greater management involvement as a positive feature in helping the development of a common agenda. Generally, the authority respondents mentioned very few disadvantages.

Only four (9%) of the 45 advisory group respondents without existing agreements thought that an agreement would be useful against 18(49%) of the 37 family health services authority managers who did not have one. Most advisory group respondents without agreements thought the disadvantages of greater family health services authority intervention would outweigh any potential benefits and several authority respondents were also concerned that requiring such an agreement might damage the relationship they had built up with the advisory group. A minority of both groups gave more positive reasons for not developing agreeements. They were pleased with how things were going and saw no benefit in formalising a flexible relationship that was already working well on the basis of mutual confidence.

Fifty (59%) authority respondents and 48(53%) advisory group respondents expressed specific concerns about the mechanisms for maintaining contact. The main problems identified by authority respondents were that contact was too limited and that there was insufficient coordination of activities between advisory group and family health services authority. Although some advisory group respondents shared these views, others were concerned that any closer contact might be used by the family health services authority to exert inappropriate control over the advisory group, and some felt this had already happened.

Forty one (48%) authority respondents were satisfied without qualification with the arrangements for maintaining contact with the advisory group and 12(14%) were dissatisfied. None of those who were dissatisfied were members of their advisory groups compared with 16(39%) of those who were satisfied and several specified that they would like to be. Only six (50%) of the dissatisfied respondents had regular meetings with their advisory group chair, against 40(98%) of those who were satisfied. Only four (33%) of the dissatisfied respondents said their medical adviser was a member of the advisory group compared with 21(51%) of those who were satisfied. Dissatisfied respondents were also less likely to receive regular written reports of advisory group meetings than satisfied respondents (two (17%) *v* 17(41%) respectively). It should be noted, however, that some authority respondents whose formal contact with their advisory group was just as limited did not identify this as a problem.

### PLANNING FUTURE WORK OF ADVISORY GROUPS

We focused on the financial year 1994–5, which had just begun at the time of the survey, to find out how far family health services authorities had been involved in planning the advisory group's strategy for the coming year.

Nearly all advisory groups had already set their objectives for the year and the remainder were in the process of doing so. Seventy four (87%) of the authority respondents thought their views had been sought and 70(82%) believed they had been taken account of in some way by the advisory group. Forty seven (55%) thought family health services authority priorities had been explicitly incorporated into advisory group plans, but from the advisory group responses it seemed that what this meant was very variable. Generally, suggestions from the family health services authority seemed to be adopted to the extent that they coincided with the advisory group's own views. Thirty three (39%) of the authority respondents mentioned specific concerns about their opportunities to influence advisory group plans. The main problems identified were the lack of adequate formal arrangements for family health services authority input, the fragility of agreements dependent on good will, and the constraints on communication imposed by advisory groups' preoccupations with confidentiality.

Forty seven (55%) of the authority respondents were satisfied with the family health services authority's opportunities for input into advisory group plans and 14(17%) were dissatisfied. The dissatisfied respondents were much less likely to believe that their views had been taken account of by the advisory group than the satisfied respondents (five (36%) *v* 43(91%).

### FAMILY HEALTH SERVICES AUTHORITY SATISFACTION WITH ADVISORY GROUPS

Table 6 summarises the data on satisfaction of family health services authorities with advisory groups. Overall, authority respondents seemed to be reasonably satisfied, some were fulsome in their praise: "I am always amazed by the wide scope that the advisory group covers. We are lucky to have a band of real enthusiasts who really do manage to cover a demanding agenda successfully." However, 23(27%) authority respondents were not satisfied in at least one area and 14(16%) of these were dissatisfied in more than one.

Satisfaction among authority respondents and the size of the district (number of practices) or whether the district was predominantly rural or urban was not associated. Rather, the respondents' comments indicate that satisfaction depended on the compatibility between the views of the family health services authority and advisory group of the role of the advisory group. Although many of the authority respondents would like advisory group and family health services authority to develop a more integrated or coordinated strategy than had been agreed so far, most were aware of the sensitivities surrounding medical audit and accepted that progress might be slower than they would like. The relative freedom that advisory groups have so far had to develop their own agendas was seen as "a price worth paying" in the short term to get audit soundly established in general practice. Some authority respondents valued the flexibility of the arm's length relationship they had developed with the advisory group and were happy to maintain this, but most were beginning to formalise arrangements or were expecting to be able to do so. Those who were happy with the current status of a semi-independent advisory group or who thought that the advisory group was progressing at a reasonable pace towards a more cooperative model were generally satisfied. Those who thought the advisory group was moving unnecessarily slowly were more likely to express frustration with what they saw as excessive caution. A few authority respondents were sceptical about the prospects of ever developing closer collaboration because of what they saw as inappropriate ideas about the advisory group's role: "The advisory group believes that it is not a subcommittee but quasi-autonomous and that it should decide how it spends the totality of its financial allocation. It is resistant to any direct input from the family health services authority, which it regards as interference. There is a degree of paranoia." A few family health services authorities had dealt with what they regarded as intolerably unbiddable advisory groups by taking direct control and restructuring the group. At the time of this survey one advisory group had ceased to function as a consequence of such action because nobody was prepared to act as chair.

## Discussion

The family health services authority respondents in this study had considerable expectations of their advisory groups, wanting them both to develop their audit activities in line with current policy and to broaden their contribution beyond audit into wider areas of quality. Most advisory groups seemed to share these interests and aspirations and have already expanded the scope of their audit activities to incorporate multidisciplinary perspectives and topics of local or national interest. In addition to audit, a substantial proportion of advisory groups have begun to help their family health services authorities in a wide variety of quality assurance and provider development activities

*Table 6 Family health services authority (n = 85) satisfaction with the advisory group in four domains. Figures are numbers (percentages) of respondents*

| | *Satisfied* | *Satisfied with reservations* | *Not satisfied* | *Unsure* | *No response* |
|---|---|---|---|---|---|
| Strategy for promoting audit | 44(52) | 30(35) | 7(8) | 2(2) | 2(2) |
| Type of information provided to family health services authority about activities and local progress with audit | 31(37) | 40(47) | 14(17) | 0 | 0 |
| Present arrangements for maintaining contact with the advisory group | 41(48) | 32(38) | 12(14) | 0 | 0 |
| Family health services authority's opportunities to have input into the advisory group's planning of subsequent year's work | 47(55) | 24(28) | 14(17) | 0 | 0 |

and many more are interested in developing such joint initiatives. However, in their comments advisory group respondents made it clear that they regard these developments as expanding rather than replacing the advisory group's original role of facilitating practice based audit and are concerned not to jeopardise this core function.

The quality and availability of information about the advisory group's progress with audit attracted the most concern from managers and problems relating to this were also recognised by advisory group chairs. The shortage of valid and informative meaures of audit activity and audit outcomes and the specific difficulties advisory groups face in obtaining reliable data are widely recognised.[8] Nevertheless, most advisory groups seem to be collecting and collating a wide range of different types of information. However, much of these data are not passed on to the family health services authority. Whether this is because of doubts about the validity or utility of the data, lack of resources within the advisory group to process them appropriately, or concerns about breaching confidentiality is not clear.

Many advisory groups have now developed more formal and systematic links with family health services authority management than were originally envisaged and, mostly, these are regarded as beneficial. In particular, regular, direct personal contact is widely valued. The main benefit of increased contact seems to be better communication. In some districts information exchange and contact remain more limited and often this seems to be associated with dissatisfaction. However, whether the lack of contact is the cause or simply a symptom of problems in the relationship between advisory group and family health services authority is not clear. Managers who are dissatisfied may also be more demanding and some advisory groups may have reacted to what they regard as excessive or inappropriate expectations by taking extra care to keep their distance. Certainly the reverse seems to be true: several advisory group respondents commented that it was because they felt able to trust the family health services authority that they were willing to work more closely with it.

Although most family health services authority respondents see the family health services authority as having some influence on advisory group strategy, the extent to which family health services authorities directly affect their advisory groups' plans is not clear. Advisory groups and family health services authorities seem to have much in common in terms of shared priorities for audit, but this may have relatively little to do with successful negotiation. Rather, both groups seem to be moving independently in similar directions in response to the wider health agenda and the evident needs of local primary care.

Given the sensitivities surrounding medical audit and the unique status of an advisory group as a statutory, yet semi detached, professional subcommittee of the family health services authority, it has been apparent from the start that constructive partnerships between advisory group and family health services authority would require a degree of good will and accommodation on both sides. The evidence from this study suggests that most advisory groups have succeeded in developing work programmes which have kept up with the changing brief for audit and continue to be regarded as appropriate and relevant by managers. Although some managers would certainly like tighter formal control over local audit policy, the flexibility of the original advisory group brief seems to have served many districts well, enabling the development of locally acceptable arrangements that would be difficult to specify in national legislation.

Several family health services authority and advisory group respondents expressed uncertainty and concern about what would happen to the advisory group and to audit generally when family health services authorities and district health authorities merge, and for some the disruption had already begun. The challenge for the future will be to ensure that any new arrangements build on the experience gained by advisory groups and family health services authorities' in working together, so that the positive features of their relationships can be maintained and lessons learnt where problems have arisen.

This study was funded by the Department of Health.

1 Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients.* London: HMSO, 1989. (Cm 555.)
2 Department of Health. *Health service development – working for patients. Medical audit in the family practitioner services.* London: DoH, 1990. (HC(FP)(90)8.)
3 NHS Management Executive. *Clinical Audit. Meeting and improving standards in health care.* Leeds: Department of Health, NHS Management Executive, 1993.
4 NHS Management Executive. *Clinical Audit: 1994/95 and beyond.* Leeds: Department of Health, 1994.
5 Field R. *Letter to chairmen of advisory groups.* 16 May 1994.
6 Humphrey C, Berrow D. Developing role of medical audit advisory groups. *Quality in Health Care* 1993;2:232–8
7 Primary Health Care Clinical Audit Working Group of the Clinical Outcomes Group. *Clinical audit in primary health care.* London: Department of Health, 1995. (Report to the Clinical Outcomes Group.)
8 Humphrey C, Berrow D. *Medical audit in primary care. A collaboration of evaluative projects, 1991–3.* Leeds: NHS Management Executive, 1994.