Medical Audit Advisory Groups

An instrument for change

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Abstract This article describes the function of Medical Audit Advisory Groups (MAAGs) in England and Wales, and outlines progress in one of them over the past two years. The Department of Health required MAAGs to be set up across England and Wales by April 1991. Their objectives are: to institute regular systematic medical audit in which all practitioners take part in every practice in the Family Health Services Authority area; to ensure confidentiality of practice data; to ensure that problems revealed through medical audit are dealt with; to report to the Family Health Services Authority on the general results of the audit programme. Each of these objectives is examined, and progress in Lincolnshire is outlined.

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MAAGs

There are 98 Family Health Services Authorities (FHSAs) in England and Wales. They are responsible for managing and resourcing primary care services (doctors, dentists, opticians, and pharmacists). The Department of Health required each of them to establish a Medical Audit Advisory Group (MAAG) in April 1991. The MAAGs' task was to implement medical audit in general practice.

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The MAAGs have developed different ways of fulfilling these objectives: some use full-time facilitators, either medical or non-medical; others use teams of GPs who devote one or two sessions a month to this work. The principle behind this is to use peer pressure to persuade GPs of the benefits of medical audit. Lincolnshire has a team of eight 'audit ambassadors' who visit practices in their area once or twice a year.

Lincolnshire MAAG's approach is primarily facilitative and educational, and its policy is to encourage audit of both clinical care and service delivery. The MAAG advocates keeping audits as simple as possible, and it is emphasised to practices that the most important thing about audit is the improvement in care, not the process itself.

Training

Lincolnshire MAAG has developed its own version of the audit cycle. The essence of the concept is the comparison of activity or performance with a previously-set standard, subsequently making changes to improve the quality of care where indicated, and finally reviewing the effectiveness of the changes made. The stages in the cycle are as follows:

1 Choose topic
2 Select audit team
3 Decide criteria (*i.e. what is the ideal care/outcome?*)
4 Set standards (*i.e. what is realistic performance?*)
5 Decide audit method
6 Observe practice/collect data
7 Compare performance with standards
8 Present results and plan improvements
9 Implement improvements
10 Review performance

The medical adviser has trained the ambassadors in both counselling and audit techniques, and they have then visited GPs (and other members of the practice team where the practice has been willing). The aim of the first round of ambassadorial visits was to establish contact, to assess what level of audit activity (if any) was already going on, and to offer help in a variety of ways: general counselling, design of audits on specific topics, a visit from the audit administrator, or supplying information from the MAAG library. The ambassadors then keep in touch at agreed intervals by telephone or with further visits. Practices vary tremendously in the amount of support they needed (and continue to need): some have only been visited once, and others have had four or five visits from a variety of MAAG personnel.

The administrator has trained the practice managers and receptionists, both within the practices and by offering training workshops; practice nurse courses have been held in conjunction with the FHSA. Two study days have been held to which all members of practice teams were invited. The MAAG also has links with post-graduate medical education bodies. Over the last year several local audit group meetings have been arranged: these are lively and informal sessions (to which all members of practice teams are invited). They are held at local hotels, and always finish with a convivial dinner. These groups are beginning to form relationships

between practices in a locality, and breaking down some of the isolation of rural general practice.

Political issues

Ambassadors have been well received in the vast majority of practices: no practices have been negative about the idea of audit, though many have had some concerns about the amount of time it would take, and about the confidentiality of any information which was passed to the MAAG. Some GPs are still suspicious about how audit information will be used. No pressure has been put on practices by the MAAG to reveal actual results of their audits, but most practices have been willing to share quite detailed reports. Practices are encouraged to use audit information in building a case for increased resources.

The relationship between the MAAGs and the FHSAs can best be described as 'semi-detached'. The MAAGs are professional bodies with an educational aim, but the FHSAs are a managing body, and as such have to monitor practice performance to some extent. Thus the Lincolnshire MAAG spent its first eighteen months establishing its identity and independence. Now the MAAG is beginning to work constructively with the FHSA on matters of mutual concern. Progress on joint objectives can be made without compromising practices' confidentiality. Regular formal meetings of the MAAG chairman and administrator with the FHSA general manager have been set up in order to discuss MAAG progress and issues which affect both bodies, and to act as an arena for agreeing policy. The FHSA are currently particularly concerned about the implementation of effective health promotion and the reduction of prescribing costs, and the MAAG can help with both these objectives.

Working together

Over the past few months, the ambassadors have spent some time aggregating the data contained in the audit reports sent by practices to the MAAG: asthma, cervical cytology, coronary heart disease, diabetes, chronic disease management, drugs, health promotion, new GP Contract activities (new patient checks, three-yearly health checks, minor surgery, and over 75 screening), and obstetrics and gynaecology.

Some difficulties were encountered in this analysis: the audits examined were not carried out with this purpose in mind. Their primary purpose was to improve care in their own practice, and in most cases that has occurred. They have looked at different aspects of patient care even within the same topic, and thus it is difficult to make direct comparisons. Agreement across practices as to what constitutes an abnormal finding or a good level of care is also difficult to establish.

Having said this, significant improvements in patient care have been shown to have occurred as a direct result of medical audit. Areas in which beneficial change has occurred include the following:

- setting up and monitoring of asthma and diabetic clinics in order to ensure consistent care across the practice population;
- identification of ways of improving uptake rates and technique for cervical cytology;
- improvement in recording of blood pressure;
- improvement in use of hypertension treatment protocol;
- reduction in the number of unnecessary urine samples sent to the laboratory (thus saving resources), and agreement of a policy on the treatment of urinary tract infections;
- reduction in the number of patients taking benzodiazepines;
- improvement in recall systems for health promotion clinics targeting those most at risk;
- identification and treatment of problems in patients aged over 75;
- improvements in care for menopausal women.

Some practices are beginning to participate in group projects co-ordinated by the MAAG: joint asthma and diabetes audits are in progress, a hypertension survey is planned which will form the basis for local guidelines, and seven practice managers are currently jointly auditing telephone access to their practices. One of the side-ef-

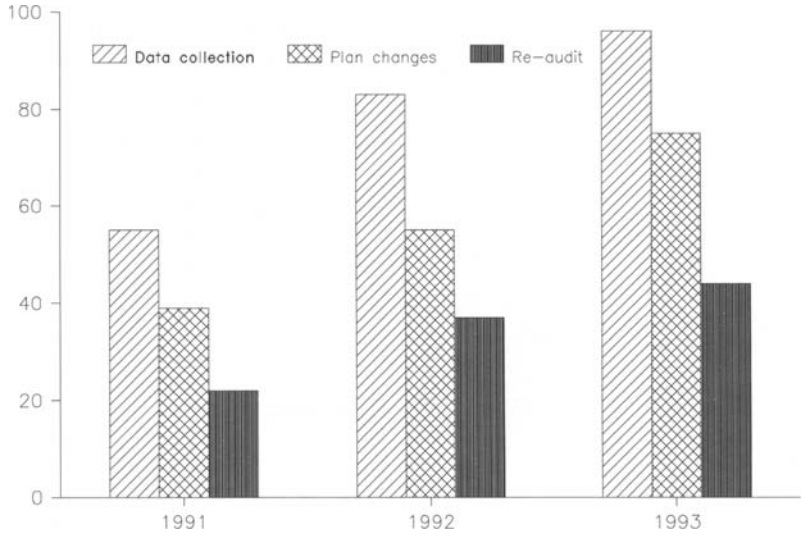

Figure *Practices' progress through the audit cycle, 1991-1993. Percentages*

fects of introducing medical audit in this way is that practice teams are beginning to feel that talking together about shared problems is not as threatening as they had feared, and can actually be a very productive use of time.

Three projects funded by the Department of Health are also in progress. The Smoking and Alcohol project compares practice data on patients' smoking and alcohol habits with responses to a questionnaire completed by hospital attenders; 57 practices and four hospitals are participating in this project. The Practice Formulary project, in which 31 practices are involved, aims to help practices set up and review practice formularies as a way of examining their prescribing. Finally, the Management of Suspected Heart Attack project follows the care of patients suffering suspected heart attacks from general practice through the ambulance service and into secondary care, particularly looking at the time between onset of symptoms and administration of thrombolysis. Future plans include examining the care of patients suffering from acute asthma attacks, and several multidisciplinary projects, including wound care, cervical cytology technique, the treatment of depression and breastfeeding rates.

Progress report

Lincolnshire practices have made considerable progress with audit activity in the first two years of the MAAGs existence. The *figure* demonstrates steady progress. By April 1993, 96 per cent of practices have got as far as or further than the stage of data collection, 75 per cent are at the stage of planning improvements or further, and 44 per cent have implemented changes and reviewed them.

Stress has been laid on looking forwards, rather than backwards: looking for scapegoats has no place in quality improvement. The 'no-blame' approach advocated by the MAAG addresses the real issues, that is, clinical care and service delivered to patients, and is effective in producing positive changes in those areas.

It must be recognised that the culture change which is taking place in general practice is of some magnitude, and more time will be needed to ensure that the principle behind medical audit, which is reflective practice leading to continuous healthcare improvement, is fully embedded in general practice before withdrawing the support of the MAAGs.

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