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PURCHASING CLINICAL AUDIT

A study in the
South and West Region

MARK EXWORTHY



Occasional Paper

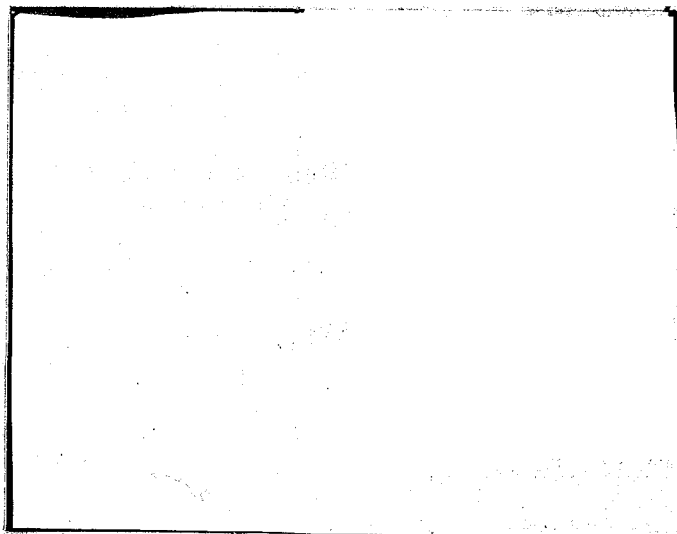
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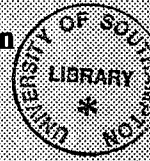
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**Institute for Health Policy Studies
Faculty of Social Sciences
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Acknowledgments

This study was completed with the help of many people.

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I would also like to thank Lyn Cutler who helped produce this report.

Glossary

CA	Clinical Audit
COG	Clinical Outcomes Group
DPH	Director of Public Health
GPFH	GP fundholder
HCHS	Hospital and community health services
MA	Medical Audit
MAAG	Medical Audit Advisory Group
PAM	Professions Allied to Medicine
PHC	Primary health care
WfP	Working for Patients

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1. Introduction

This report examines the implications of the transfer to health authority purchasers of responsibility for the allocation of clinical audit funds for hospital and community health services.

This report is based on a study commissioned by the South and West Regional Health Authority in the summer of 1994, lasting for one year. It began soon after purchasers had acquired such responsibilities from the Regional Health Authority (in April 1994) and examined the ways in which purchasers were undertaking and planning to undertake their new responsibilities. It also explored the impact of actual or potential purchaser decisions upon providers and the ways in which these providers were reacting and planning to react.

1.1 Project aims

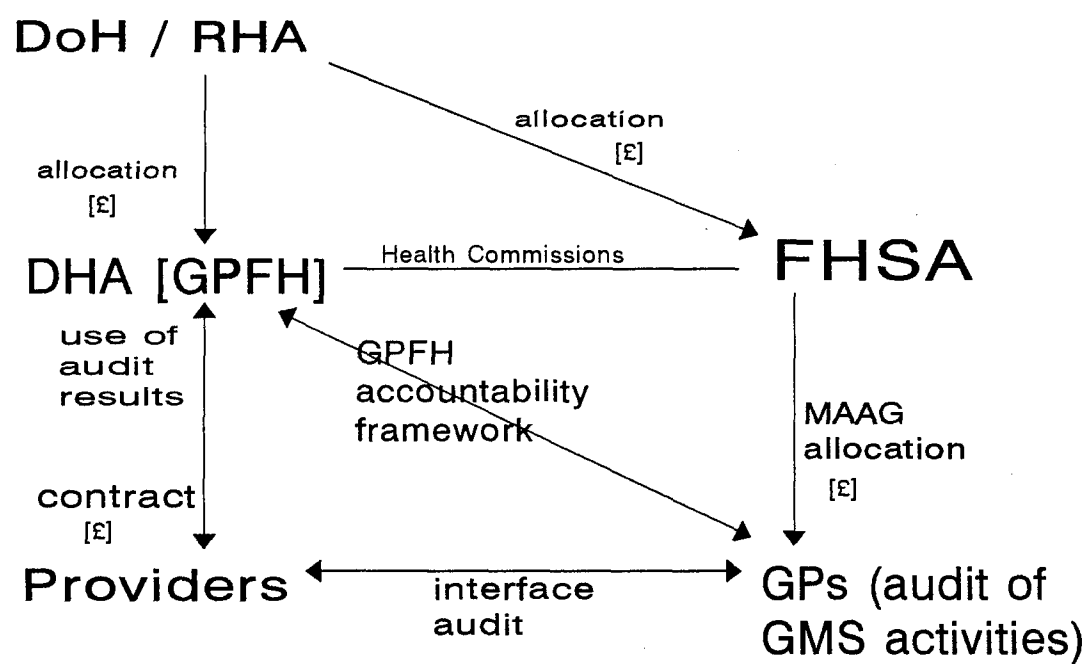
The project had two principal aims, viz.:

1. To examine how purchasers are using, and planning to use, their new responsibilities for the allocation of clinical audit funds.
2. To identify the conditions for the appropriate development of purchasing clinical audit.

The aims were founded on the assumption that the transfer of responsibilities for the allocation of CA funds was likely to be problematic. The introduction and development of medical (uni-professional) and subsequently clinical audit since 1989 had been based on the understanding that it would remain an educational activity and be professionally-led. It appeared that this understanding, in theory, no longer held. This might represent a challenge to some clinicians as purchasers and consequently provider management would thus have greater access to the process and outcomes of CA. Given many sensitivities regarding the development of audit, this might be seen as being inimical to the further development of this activity. Purchasers might (unwittingly) damage the structures and process of provider audit programmes. Alternatively, purchasers may act as catalysts in enhancing the profile and applicability of CA. Thus, if purchasers were to ensure that CA contributed to their agenda and yet maintained audit's original goals, there needed to be

Figure 1

The organisation of Clinical Audit (post April 1994)



a greater understanding of the ways in which purchasers were responding to this potential dilemma and of the reactions of clinicians and managers in providers to this changed context.

These new organisational relations can be represented diagrammatically. Figure 1 indicates the key stakeholders in the allocation of CA funds and the linkages between them.

At the same time as purchasers acquired their new responsibilities, the audit process changed from being a medically-oriented one to one encompassing all clinical disciplines. The result was two broad approaches to audit, viz. uni- and multi-professional audit. The former represents groups of the same professionals (and would thus include medical audit) whilst the latter represents groups of different professionals working on the same audit, contributing their individual professional experience and judgement to the process.

1.2 Methods

Various methods were adopted in eliciting the views and attitudes of individuals and the strategies adopted by their respective organisations. These methods were qualitative and included a pilot study, a telephone survey of all Health Authority/Commission purchasers in the South and West Region, detailed case studies of three purchasers (and their respective providers) and analysis of documentary evidence and secondary material from the survey and the case studies. The study in the South and West was supplemented by two other strategies, viz.

- an assessment of the research literature regarding clinical and medical audit and
- the collation of evidence drawn from other similar studies elsewhere in the country.

Each method will now be briefly outlined.

i. Pilot study:

A pilot study was undertaken in order to clarify the research questions and to provide some local evidence of the issues identified through the research literature.

A meeting with (six) members of the Department of Public Health from one Health Commission was arranged to discuss some of the issues that were thought to be of concern to purchasers and providers. This discussion lasted one hour and was based on a pre-circulated agenda. Whilst confirming some initial ideas, the discussion proved useful in highlighting certain topics that were previously thought to be unimportant or not relevant (eg. the growing importance of audit links between primary and secondary care).

ii. Survey:

Prior to the start of work with the case study purchaser, a telephone survey was undertaken with each of the 7 Health Authority/Commission purchasers not included as case studies. These were conducted in September and October 1994 and lasted, on average, 25 minutes. The telephone survey was conducted with the lead officer in each Authority/Commission which, in each case, was a public health doctor. In three of these cases, this person was the Director of Public Health (DPH).

The survey was designed to provide an overall picture of the state of development in the purchasing function in the Region as it related to CA. This picture could then be compared with evidence arising from the case studies. The survey emphasised the importance of the local context of each purchaser and the variety of approaches currently being adopted across the Region.

iii. Case studies:

Given the embryonic nature of purchaser's involvement in CA and the range of possible approaches that the DOH guidance offers, an in-depth study of a selected number of purchasers was chosen as the most effective way of meeting the project's aims.

The reason for selecting particular purchasers was that they were thought to represent a range of purchasing approaches to CA. Discussions with staff from the Region and Commissions indicated that a number of purchasing approaches could be identified which ranged from directive (or autocratic) to non-directive

(or minimalist). A position of cooperation or facilitation might represent a mid-way position between these two potential ends of the spectrum. This spectrum can be represented graphically in Figure 2. The validity of this spectrum in the light of the research is discussed later (chapter 3).

The DPH in four purchasing authorities was asked (by letter) to participate in the study. Telephone discussions clarified the project's aims and the degree of involvement required by participation. One did not want to be involved and withdrew from the study.

Documentary material was collated from each case study purchaser to provide background information on the development of CA and contracting within the organisation. Interviews were held with the lead officer for CA in the purchaser (in each case, the DPH), a contracts manager with particular responsibility for or linkage to CA and a manager with particular responsibility for quality (assurance). Other staff were interviewed only where they had association with CA, usually in terms of membership of the purchaser's CA group. Across the 3 case studies, 14 individuals were interviewed.

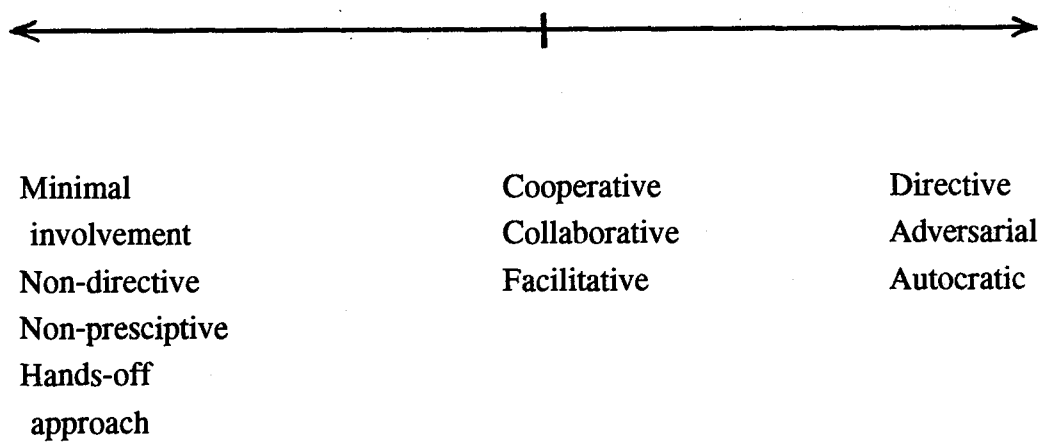
Having established agreement with the DPH, contact was made with the chair of the CA committee in two providers within the purchaser's geographical area. The chairs were asked to participate in the study and all agreed. As with the purchasers, documentary material was collated prior to interviews with key individuals involved in the CA and contracting process. The individuals included the chair of the CA committee, the CA coordinator/facilitator, a manager with responsibility for quality and/or contracting. Other individuals were interviewed only if they were thought to be especially crucial to the development of CA within that trust. In two trusts, the medical director was interviewed. Nurse Executives were interviewed in two trusts. Clinicians from the 'professions allied to medicine' (PAMs) were also interviewed in two trusts. In one case study area, three provider units were included at the request of the DPH. Across the three case study areas, 23 individuals from providers were interviewed.

Although not intended at the outset, representatives from the Medical Audit Advisory Groups (MAAGs) were subsequently included in the case studies. Indications from the pilot study and the survey suggested that the role of MAAG had increased appreciably in recent years in the light of the

development of primary-secondary care audit and the development of GP fundholding.

Figure 2

A spectrum of approaches to 'purchasing clinical audit'



MAAGs were therefore included. Three representatives from the respective MAAGs were interviewed.

In total, forty individuals were interviewed for, on average, one hour. They represented a cross-section of purchasers and providers as well as clinicians and managers. Interviews were semi-structured with a list of questions asked of all. Individual's responses were pursued in more depth as required. Questions were conceived from the research literature, the pilot study and the survey. Topics included:

- development of local CA in the last year
- position of CA within the organisation
- general CA strategy adopted
- process for the selection of topics
- criteria for allocation of CA budget
- monitoring of CA contract in-year
- interpretation of CA results
- possible (management) action arising from CA
- rewards and sanctions associated with CA (contract)
- professional concerns regarding the involvement of purchasers in the CA process
- degree of managerial involvement in CA
- degree of involvement by GPs in local CA and the approach adopted by GP fundholders
- future of CA

The interviews were tape-recorded with the permission of the individual being interviewed. Nobody refused. These tapes were then transcribed and then analysed thematically by producing interpretations and theories.

Two important topics (patient involvement in CA and inter-agency audit) were omitted from this study because they were the subject of a parallel project undertaken by Sue Barnard at the Social Services Research and Information Unit (SSRIU) at Portsmouth University. That project was conducted over the same timescale as this one. The two projects collaborated over issues of selection of case study areas, linkages between emerging themes and resolution of methodological and operational difficulties.

Attendance and participation at selected CA meetings of purchasers and providers supplemented the methods outlined above. This has been combined with an active process of feedback to case study participants to ensure that the collation and interpretation of material gathered has been valid and accurate. Likewise, feedback to conferences and seminars have also been pursued during the study period.

1.3 Possible confounding factors

Within a relatively short period of 'fieldwork' time, a number of confounding factors may have arisen. For example, by taking a policy analysis approach to the subject, there was a bias in terms of the people interviewed. Those involved with the CA policy process tended to be those individuals who were, in general, 'enthusiastic' about CA and therefore promoted it. As such, CA 'sceptics' were generally not included in the study. Their views about the value of and approach to purchasing CA would have probably been quite different to those interviewed. Many spoke of their colleagues' scepticism to audit. However, the remit of the project did not lend itself to their inclusion.

A case study approach within one Region inevitably limits the type of purchasers included. Purchasers elsewhere in the country may have been pursuing different strategies that might have informed the study's aims. This shortcoming has been minimised by contact with some Regional Audit Coordinators, individuals from the DOH and the NHS Executive as well as a range of people involved in research and evaluation of CA.

As the study's 'fieldwork' took place between November 1994 and February 1995, the study may have limited its effectiveness in that many purchasers were only beginning to come to terms with their new responsibilities for the allocation of CA funds. Therefore, clear policies might not have been expected at this stage. However, the purpose of the study was to explore purchasers' strategies in the light of their developing position and thus to offer guidance to them in formulating their emerging policy towards CA.

Buxton (1994) suggests that research on audit can be affected by the 'Hawthorne' effect which means that subjects behave in a way they think is expected of them because they know they are being observed. Thus, "the very act of evaluation is likely to change the qualitative nature and perhaps even the

quantitative substance of the audit under evaluation" (p.32). Data collection from various sources and cross-referencing of material can minimise this effect.

1.4 Structure of report

The report is divided into 3 main sections. The first section deals with the context of CA (chapter 2) and a review of literature relating to CA and purchasing (chapter 3).

The second section addresses the findings of the project according to several issues. These include the organisational setting of CA (chapter 4), the selection of CA topics (chapter 5), CA funding, contracts and contracting (chapter 6), managerial involvement in CA (chapter 7) and also primary health care audit (chapter 8).

The third section (chapter 9) places the findings of the project in the light of the lessons emerging from other evaluations and research. The themes addressed here are those of accountability and the future of CA. The report ends concludes by offering conclusions and recommendations to purchasers and providers regarding the future development of CA.

2. Context of Clinic Audit

This chapter provides a background to the development of audit in health services in the UK and outlines recent policy developments regarding audit. It also briefly describes developments in the organisation of purchasing since purchasers have recently become formally associated with CA.

2.1 A brief history of audit

Although professional bodies have long been concerned with the standards of professional practice, Walshe and Coles (1993) argue that "perhaps the first documented quality assessment studies were undertaken by Florence Nightingale, who used data such as mortality rates for diagnostic categories to highlight unsafe conditions in Crimean British Army hospitals" (p.22). Individuals such as Groves and Codman were also early pioneers in audit. The origins of (medical) audit within a professional body can be traced to the American College of Surgeons who established the National Standardization Programme for hospitals in 1919.

However, it was not until the 1960s that audit became a formal activity in the USA. Many audits began as case reviews or as mortality and morbidity meetings. In 1966, Donabedian provided audit with a framework by proposing three elements to the then existing peer review system, viz. structure, process and outcome.

By the mid-1960s, the publicly funded schemes of Medicaid and Medicare programmes were established but their costs were higher than expected. Utilisation reviews were used to inspect the economic efficiency of treatments. The expense of this system, proved unworkable (Freidson, 1976) and the emphasis moved to a focus on the quality of care according to medical criteria. This change of emphasis led to the establishment of the Professional Standards Review Organization (PSRO) in 1972 (Sanazaro, 1974). The formation of the PSRO involved a shift from reviews of individual cases to more explicit criteria for assessing the effectiveness of care (Dent, 1993).

Although forms of audit such as the Confidential Enquiry into Maternal Deaths have existed since 1952, Dent (1993) identifies the Cogwheel reforms (Godber and Brotherstone committees) in 1967 as critical to the development of audit

in the UK. The report for England and Wales referred to reviews of clinical practice but only the Scottish report mentioned medical audit. Dent (1993) sees the period prior to the 1972 DHSS re-organisation (Grey Book) as crucial since the medical profession feared that audit would be introduced and controlled by the new division of Community Medicine (subsequently Public Health Medicine). This fear proved to be unfounded at the time (BMJ, Supplement, 1973, 29) but now, public health medicine plays a key role through the purchaser organisation. The medical profession only formally accepted a policy of audit in 1981 (BMJ, 1981). This reflected growing concern over evidence of often wide and inexplicable variations in practice.

2.2 Audit since 1989

The NHS Royal Commission (1979) recommended a policy of audit or peer review. The Social Services Select Committee (1988) also proposed that clinical performance should be assessed by self-audit, peer review or management. However, it was only in the 1989 'Working for Patients' (WfP) white paper that these calls became formalised. Working paper number 6 defined medical audit as "the 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 and quality of life for the patient..." (para.1.1).

This definition refers to cost and clinical effectiveness and so the Public Accounts Committee was concerned with the ways in which audit would assist the 'financial management of the NHS.' It concluded that audit might be structured "through some form of contractual arrangement" (1989, vii, para.9). However, it was five years before audit was formally placed in a contractual setting (see below).

Local audit mechanisms were established in April 1991 through the formation of medical audit committees in provider units, as required by the 1990 NHS and Community Care Act. The funding was based on the number of (whole time) physicians working in that provider. The model of audit adopted was largely a medical one and it included the following features:

- only doctors shall conduct audit,
- audit should be educational,

- participation should be voluntary,
- standards should be set locally,
- confidentiality should be ensured and
- action following audit should be a medical, not a management problem

These features are drawn from reports from the Royal College of Physicians (1989, 3), the Royal College of Surgeons (1989, 3) and the Standing Committee on Postgraduate Medical Education (1989, 11).

The White Paper proposed that "the general results of medical audit should be available to management locally and the lessons published more widely" (WfP, 1989, p.41). The experience of management involvement has been mixed and has ranged from membership of provider audit committees to an expression of reluctance and, in some case, refusal. (Managerial involvement in CA is explored in chapter 7).

Several concerns underpinned the reasons for the formal inception of audit at the same time as an (internal) market was introduced. Concerns were raised in many quarters that financial considerations would outweigh clinical decisions and the quality of clinical care would consequently suffer (Butler, 1994, 19; Harrison *et al*, 1992, 142). Provider units' finances were now much more closely tied to clinical decisions. Thus, the introduction of audit could be interpreted as a way of the government (Department of Health) mollifying the medical profession's (and other parties') concerns. This process was eased by funding medical and clinical audit by approximately £50 million per annum (Walshe and Coles, 1993, 1; EL(93)59).

2.3 Developments between 1991 and 1994

Between the inception of audit in April 1991 until probably its most significant change in April 1994, audit was characterised by a number of features that have shaped its subsequent development. These include the funding arrangements, the voluntary nature of participation in audit, the development of nursing and therapy audit and of Medical Audit Advisory Groups (MAAGs).

Funding was dominated by the medical profession in the early years of audit. Its funding was based on the number of whole time medical and dental staff in each (provider) unit. This meant that those units with large numbers of physicians (such as the acute sector) received large audit sums whereas community health services units (with small(er) physician numbers) fared less well. The funding arrangement helped, in part, perpetuate the impression held by many that audit money was a source of semi-research money for large acute units as well as the impression that it was an esoteric activity for doctors.

Voluntary participation in audit had been a feature secured by the profession but this led to variable rates in the diffusion of audit. Whilst some embraced its concepts enthusiastically, others declined to be involved. It is difficult to assess these rates of participation because, although attendance rates have been collected for audit meetings, this hardly indicates the degree to which clinicians were addressing elements of the 'audit cycle' or even completing it. Its voluntary nature may have secured a foot-hold and thus ensured an easier introduction into clinical practice but it may also have proved to be more problematic in the transition of audit from an esoteric activity to a more mainstream one. Whilst there may be resistance to audit's introduction, the ground had been prepared to some extent through the acceptance by various parts of the profession and its operation in the USA. Harrison *et al* (1992) clarify this development by indicating that CA did not represent a sudden upsurge of interest in the medical profession. This paper explores the tensions surrounding this transition of audit into a more 'mature' setting.

Nursing audit has had a different history to medical audit in the sense that many systems for assessing quality of care had been established in the 1980s. The development of audit in professions allied to medicine (PAMs) was similar. Nursing audit has used these systems and evolved to the point where Harrison and Pollitt (1994) identified four key features, viz.:

- less focus on administrative arrangements than medical audit
- nursing audit outcomes available to local management
- more clearly defined professional management structures than the medical profession
- many nursing audit systems designed to consult patients (p.105)

Such audit has essentially been related to service quality issues although interest in clinical outcomes has been developing recently. However, many of these initiatives have been running independently of medical audit. The funding for nursing audit has been significantly less than that of medical audit although nurses out-number doctors. Between 1991 and 1994, £17.7 million was allocated to audit by nurses and PAMs (EL(93)59).

Although primary health care audit was not envisaged as a formal part of this study, it is important to highlight its recent development since it is increasingly becoming linked with HCHS audit and contracting. MAAGs were established in 1991 and, like provider audit development, attention was initially given towards setting up committees and teaching audit techniques. Although MAAGs have remained separate from much recent policy guidance (see below), they must submit annual accounts to the FHSA who needs to be reassured that the MAAG's programme is effective. Some MAAGs are moving towards a more formal agreement with the FHSA as they merge with DHAs. This move will be underlined as primary care and especially GP fundholding becomes more central in health policy. 'Interface' (inter-agency) audits will thus assume much greater importance but, in consequence, their functions and links with trust colleagues and purchasers will need to be clarified.

2.4 Recent policy changes

Several changes were introduced in April 1994 that marked a sea-change in the development of audit. These changes included:

- move to CA
- removal of separate funding and programme streams
- purchaser allocation
- per capita funding

These changes were introduced following a number of Executive Letters and policy guidance. These are summarised below.

i. EL(93)34 (23 April 1993):

This Letter identified the budget for 1993/94 including a sum of £3.2 million to "facilitate and pump-prime the development of multi-professional clinical audit." The Letter was particularly significant for signalling the end of separate

audit programmes (medical, nursing and PAMs audit). It also stated that "Regions are asked to promote the use of the clinical audit programme as part of the purchaser's role in contracting."

A paper on 'audit and the purchaser/provider interaction' formed an annex to the Letter. This set out a new vision for audit, different from WfP:

- audit will be multi-disciplinary (professional) and part of quality management programmes
- audit will be informed by purchaser/provider and public/patient as well as professional priorities
- audit findings will inform service development and purchasing
- audit will be part of routine activity and professional education
- audit will demonstrate its effectiveness
- audit will focus on outcomes
- audit will be a shared process between primary and secondary care

A number of guidance notes followed for those at the clinician/provider interface, purchaser/provider interface and at the regional level.

ii. Clinical Audit: meeting and improving standards in healthcare. (EL(93)59)

The fourteen page booklet accompanying this EL recalls some of the "general principles", background of CA and the funding of CA programmes. It states that between 1989 and 1994, £220.7 million was allocated to medical, nursing/therapy and primary care audit. (£160.8 million of this figure was spent on medical audit over the same period). It introduces the idea of "networking/infrastructure" by outlining the groups and initiatives involved in promoting CA. Pointing a "future direction" for CA, it reasserts the professional role but highlights purchasers' and managers' involvement: "The practice of audit remains a professional activity. Purchasers of health care, health service managers and patients however will increasingly influence the audit programme" (p.13).

iii. EL(93)104 (29 November 1993):

This Letter indicated the funding for clinical audit in 1994/95 "and beyond." It stated that funding would be on a population basis. Although Regions were

able to "determine the most appropriate funding route/formula", they were required to account for the development of multi-professional CA. The Letter also indicated the continuation of MAAGs. It highlighted the move towards the funding of CA through the purchasing process, one which was identified as complicated and challenging. A working party of the Clinical Outcomes Group would therefore examine the models for future funding of CA (see EL(94)20, Annex C).

iv. EL(94)20 (28 February 1994):

This Letter introduced the annexes which were the result of the C.O.G. working party. It recognised that the attached advice may have come too late for inclusion in that year's contracting process but that it would guide future contracting negotiations.

Annex A outlined the roles and responsibilities for RHAs, DHAs, and trusts. These included the suggested contracting mechanism for CA, viz. a "3 year rolling lead purchaser contract." However, once this was embedded, the annex implied that a scheme of funding "recovered from individual contracts may be appropriate."

Annex B was a code of practice for clinical audit. It identified several broad policy principles for CA which were:

- "to promote sharing of audit findings to inform the purchasing intentions of all interested parties
- to ensure that audit resources are used for provider based audit activity and are not misused for general contract monitoring purposes...
- to respond to the views of local patients and patient advocacy groups"

Annex C summarised 8 models for future CA funding. These were:

- continued top-slicing by intermediate tier
- tasking of funding by intermediate tier
- block contract between purchaser and provider using host purchaser mechanism
- funding as a percentage of contract costs

- bottom-slicing by providers
- funding through education bodies
- purchasers to provider audit support
- combination of the above

The preferred option was the 'block contract' since it overcame funding uncertainty and it was a similar approach to R&D and education. Easier administration and enhanced accountability were also seen as benefits of this approach. The host purchaser mechanism would ensure that providers did not need to enter into multiple contracts with several purchasers.

The Letter also included a 'model contract' for CA. It outlined objectives, framework, support, monitoring and payment *inter alia*. Within the framework, it stressed the "reporting general audit findings and action taken on the basis of findings to purchasers." Within the monitoring section, it recommended an allocation (presumably of funding) of 40-40-10-10 between provider priorities, purchaser priorities, primary-secondary interface and to cross unit/district/region and national audit projects. These issues are explored later in this report (chapter 6).

v. EL(94)74 (28 September 1994):

Though not specifically about CA, this Letter addresses the issue of clinical effectiveness which has become closely associated with audit. Many of this Letter's statements reinforced CA policy. For example, it states that "commissioners and providers are likely to find the local advisory machinery associated with clinical audit... useful in developing local documents and securing their implementation in changing clinical practice" (para.17). Links with primary care and the involvement of patients are also stressed.

vi. DoH (1993) The evolution of clinical audit:

This report offers "practical measures needed to support the evolution of clinical audit." It does this by looking at a number of issues such as:

- characteristics of CA
- related activities such as R&D
- patient benefit through CA
- professions' approaches to CA
- skills required for CA

- audit and professional development
- infrastructure for CA
- clinical guidelines
- role of the purchaser within CA

The section relating specifically to purchasers is limited to half a page and concludes with a recommendation to "develop mechanisms to ensure multi-professional input to the audit process in purchasing including GP fundholding" (p.23).

vii. Wessex RHA (1994) Purchasing clinical audit: guidelines for action and review criteria for Health Commissions.

This paper provides a precis of some of the Executive Letters already outlined here and summarises the roles of purchasers, providers and the RHA.

Purchasers should, according to the paper, "generate plans for the development of clinical audit across all their main providers..." and "should promote the principles of audit in their contracts with units/trusts..." (p.2). In addition to the DoH's minimum data set for CA, Wessex RHA identified assessment criteria for monitoring CA. These were:

- "professionally led
- essentially educational
- addressing timeliness, appropriateness and effectiveness of interventions
- using criterion referenced approach
- focus on patient/carer
- undertaken by clinical teams
- involving general management
- maintaining confidentiality...
- informing purchaser and provider strategies
- linking to HOTN, R&D, DEC [Development and Evaluation Committee]." (Appendix 5)

viii. Regional Medical Audit Coordinators Committee (n.d., probably early 1994) Commissioning Clinical Audit:

This paper looked at various aspects of the developing purchasing function in CA. It noted the steady development of quality in audit contracts but, in

relation to the ear-marking of audit funds and to ensuring professional ownership, it questioned how long this 'co-operative' model should continue as contracting became more 'sophisticated.'

The paper also identified a balance between "the cultural shift versus statistical monitoring" and advocated that "leading edge" purchasers should develop more advanced approaches "when they have the confidence that the cultural changes are finally in place" (p.5). The paper also expressed the need to minimise the information needs for audit and for contracting whilst facilitating the "cultural shift" of clinicians' attitudes towards changing clinical practice.

ix. Clinical Outcomes Group: CA in primary health care (July 1994):

This comprehensive report examined the "ways in which clinical audit can be developed in primary health care", the means of involving managers in primary care audit and the use of CA as a tool of quality improvement. Recognising the "remarkable progress" in implementing primary care audit, the report outlines ways in which audit could be enhanced through "quality assurance in practice", "contracting and commissioning", "service developments" and education. The report concludes that audit should encompass the wider clinical team in primary care, that it should involve managers and purchasers and that it provides an opportunity for clinicians to "express the traditional concept of a profession in modern times." This report is explored further in chapter 8.

2.5 Conclusion

Placing the historical development of audit in the context of recent policy guidance indicates the ways in which audit has evolved and matured. Whilst this general development has been a relatively slow process, the pace of change has accelerated markedly in recent years to the point where CA is no longer advanced as an esoteric activity. Instead, it is promoted in conjunction with a variety of other current initiatives in the NHS such as research and development, the promotion of clinical effectiveness, the development of trust and purchasing organisations. However, whilst some of the principal features of CA have substantially remained the same, its new operating environment does demand a fresh approach, one that recognises the multiple objectives that audit now plays and the many stakeholders that are involved.

3. Literature Review

The literature relating to clinical audit and purchasing is increasing rapidly. In order to structure this review, the focus will be on four areas:

- the 'philosophy' of CA
- purchaser involvement
- professional-managerial tensions and
- evaluation of CA

3.1 Philosophy of clinical audit

The need for a critical look at CA:

Many people see audit as a 'good thing', an activity that is inherently beneficial which may explain why audit was perhaps the least contentious aspect of *Working for Patients* (WfP) (1989) (Buxton, 1994). However, audit in itself should not be seen as uncontentious for Power (1994) argues it "is hardly an unambiguous concept and it could be argued that the practices to which the label is attached are in fact diverse and that they are constituted by very different bodies of knowledge" (p.4). McSweeney (1988) argues audit is not just descriptions and the values underlying them influence alternative policies and priorities. Therefore, enthusiasts promoting audit may offer a misrepresentative picture of clinicians as a whole. Buxton (1994) suggests that audit was until WfP the preserve of innovators and hence was undertaken in atypical settings. The Hawthorne effect explains the difficulty of undertaking research on atypical subjects. For Buxton (1994), the Hawthorne effect would mean that "results from studies would be more positive than the results in (unobserved) practice, further weakening the generalisability of the limited evidence of possible impact" (p.32).

A more critical examination is needed of what audit means and where it fits in relation to quality improvement and professional practice, for, as Walshe and Coles (1993) indicate "success [of audit] is simply not proven" (p.36). Nolan and Scott (1993) distinguish between the primary tensions within audit (concerning "the purpose and philosophy underlying audit") and the secondary tensions ("characterized more by operational issues" (p.760)). They call for a

"fundamental appraisal of the purpose and philosophy of audit" (p.765). This would address a "growing unease about the lack of evidence of the impact of medical audit as a health technology" (Buxton, 1994, 31).

Statements about the philosophy of audit may be increasingly problematic since audit can no longer be seen, if it was ever, as having a single purpose for, as Packwood *et al* (1994) suggest, "the various purposes of medical audit will... wax and wane" (p.314). Hence, audit may have multiple purposes relating to education, management, uni- and multi-professional membership, junior and/or senior staff. It will therefore depend, *inter alia*, on who is involved and who is setting the agenda.

Audit's shortcomings:

Kerrison *et al* (1993) identified audit's shortcomings as a lack of explicit and evidence-based criteria, insufficient sized samples and a failure to re-audit. Such criticism is extended by the perceived marginality of audit and the difficulty in holding audit meetings. Furthermore, the criteria used for audit are often weak and/or arbitrary which makes the lack of adherence to standards explainable by the perceived credibility of those standards (Buxton, 1994; Crombie and Davies, 1993). Funding tried to ensure the diffusion of audit but did not necessarily ensure that evidence was produced to demonstrate its effectiveness. Audit's growing links with the Research and Development initiative may, however, help to overcome these difficulties. Buxton (1994) therefore summarises audit as "a complex and not easily replicable technology" (p.33).

Black and Thompson (1993) explained that (medical) participants in their study criticised the implementation of audit rather than its principles. Four main reservations were identified: the role of audit, practical aspects, the effectiveness of audit and anxieties about the use of audit. Unless these are addressed, Black and Thompson (1993) argue, funding, persuasion and directives will have little impact.

Many doctors in their study felt that audit, though a long-standing activity of some, was now being formalised and encouraged for cost saving purposes as much as for 'quality improvement.' Who and what was audited were two further concerns expressed. Junior doctors felt that their work was being monitored and it was administrative issues rather than clinical ones that should

remain the focus of audit. Questions about the role of audit mirrored anxieties about its uses including fears about audit as a way of 'intimidating' doctors, the growth in audit spending, the legal implications of audit and the growing involvement by managers. Practical aspects expressed included the need for developing a supportive environment, the lack of time available for audit, the extra work that was generated by it as well as the limited understanding of audit methods. Moreover, juniors' short-term contracts ensured few completed the audit cycle.

The advent of central government funding has heightened questions of audit's effectiveness, a concern expressed in Black and Thompson's study. Maynard (1991) suggests that "the government is pouring money into the 'black hole' of medical audit" which paralleled concerns of participants in the Black and Thompson study. [CASPE Research was commissioned by the DoH in 1993 to evaluate audit and has published its findings (see 3.6)]. Maynard proposes that "medical audit alone is unlikely to translate good practice into common practice" whereas Black and Thompson emphasise the possibility that doctors might appear to change practice so as to produce better audit results.

Black and Thompson make five conclusions from their study:

- interest groups may seize audit for their own purposes
- medical complacency gives audit an administrative focus
- doctors remain unconvinced by the value of audit
- few doctors are skilled in audit techniques
- many doctors feel unable to comment on the performance of colleagues

The need to examine the purposes and philosophy of audit can be summarised in the words of Packwood *et al* (1994):

"audit is a fragile process; it can be readily ignored or omitted, its results argued away as idiosyncratic, its insights seen to be duplicated by other sources, its purposes conflicting, with no perception of any serious detriment to medical practice resulting from its absence" (p.310).

3.2 Purchaser involvement in clinical audit

"Purchaser-provider interaction is potentially both a saviour of and a threat to audit. If misapplied, involvement of purchasers could lead to a decline in audit. If both purchasers and providers can establish mature and informed communication then the future of audit can be assured." (Thomson and Barton, 1994, 227).

In general, most purchasers were notably absent in the debates relating to audit before April 1994. The formalisation of audit in 1991 had ensured that it began as a provider concern focusing on the professional and educational process, with little connection to broader issues such as purchasing.

Audit and purchasing before 1994:

Prior to 1994, a number of commentators had highlighted the problems and potential of involving purchasers in various aspects of audit. For example, Pollitt (1993) explained that "if and when purchasers are able to conduct quality comparisons in this way [provider comparisons via audit] then a potentially important lever of influence will have been added to the managers' armoury" (p.164). Packwood *et al* (1992) saw that a "contract specification by purchasers would... determine the nature of medical audit, presenting a significant shift away from the principles of professional and provider control that initially shaped its organisation." In a later paper (1994), they saw that quality assurance such as audit might be one basis for securing and renewing contracts. Provider managers would thus need to become more closely involved in audit matters.

Three key areas relating to purchasing and audit will be examined, viz. the reasons for purchasers' involvement in CA, the difficulties and opportunities of this development and the possible strategies that purchasers might adopt.

Effective purchasing criteria:

In parallel with debates about the effectiveness of purchasing in general health service reforms (Hunter and Harrison, 1993), it is difficult to isolate the contribution of the purchasers *per se* to improvements in the quality of care or that of CA. Most research evidence regarding purchasing has focused on GP fundholders but this does not really illuminate the CA question.

The few commentators who have proposed criteria for effective purchasing have included 'quality' (Kerr *et al*, 1993; Hunter and Harrison, 1993). None have explicitly included clinical audit although many such criteria were proposed before audit became a formal purchaser responsibility. Outcome evaluation has been included in criteria developed by Prowle (1992) and Hunter and Harrison (1993).

Mawhinney (NHS.ME, 1993) identified the use of local CA as a guiding principle for purchasers. He emphasised that purchasers must have "confidence in local audit programmes" and "should seek to influence audit programmes" (p.50). Recognising the need for purchasers to be assured that action was taken as a result of CA, he urged purchasers "not to be afraid if necessary to use the contracting process to make sure this happens" (p.50). However, his criteria become tautological in that effective purchasing is characterised by involvement in CA and that the effectiveness of CA is enhanced by purchaser involvement.

External quality monitoring:

Various reasons underlined the re-location of responsibility for CA funding to Health Authorities including the demise of Regional Health Authorities and development of (strategic) purchasing. The re-location placed audit within an external environment, so that it was no longer being solely concerned with internal quality assurance. Wareham (1994b) stresses the balance to be struck between internal and external quality monitoring so that these, apparently separate concepts are "compatible and supportive."

Some see the aims of external monitoring as more than the guidance which states that "purchasers should promote the principles of audit through contracts with trust/units" (Wessex RHA, 1994, p.2). Evidence from America suggests that the aims of external quality monitoring are "split between public protection, quality improvement and cost containment" (Wareham, 1994b, 106). A similar split of objectives may be manifest in the UK. Whether the different aims of external monitoring plus those of provider-based initiatives can be combined is debatable (see chapter 9). Longley (1993) sees a confusion arising "between medical audit and monitoring value for money in NHS government literature" (p.57). Though both are legitimate, she claims, they also have different aims.

Rumsey *et al* (1994) advocate that purchasers, in clarifying their role as external monitoring agents, "should try to define explicitly... the legitimate nature and extent of their interest and involvement in audit" (p.52). They recognise that purchasers should be concerned with strategic issues and question their involvement in operational issues.

Accountability:

Although some claim that audit was never intended to be an accountability mechanism (*cf.* professional and educational), this position has been eroded by government policy encouraging management and purchaser involvement. Three aspects of accountability, pertinent to audit, are discussed below.

Firstly, Packwood *et al* (1994) argue that the transfer of aggregate information to managers has not been particularly illuminating and Pollitt (1993) agrees to the extent that more than just the release of information is required. He suggests that effective sanctions and/or incentives would be required to penalise or reward high quality providers if audit results were passed to purchasers. Even provider managers would require some degree of sanction or reward to act upon the information. Otherwise, Pollitt (1993) argues, clinicians would "face nothing more galvanizing than periodic embarrassment" (p.210). Such mechanisms are required since the process of audit is left to clinicians and managers can only exert leverage over the outcomes (products) of audit to promote accountability (Power, 1994).

Secondly, audit in itself se does not necessarily provide accountability to external parties such as purchasers and the public. This has been exacerbated since the removal of Local Authority representatives from DHAs and the perception of marginalisation felt by many CHCs (Pollitt, 1993). Other mechanisms are required if (external) accountability is to be achieved. Longley (1993) suggests that there is "a lack of clarity about the conception of audit with which government intends NHS management to operate and the use to which medical audit may be put" (p.57). Audit's apparent goal to evaluate the quality of care is hampered, she argues, by the lack of "adequate measures" for monitoring and improving quality. The request for an independent audit (by other clinicians or an external agency) is a last resort but has been rarely used.

Thirdly, the role of the public in health care (Williamson, 1992) and audit (Rigge, 1994) has been poorly developed. (Both are the subject of a parallel project undertaken by Sue Barnard (SSRIU, Portsmouth University)). Packwood *et al* (1994) argue that the process of audit is "opaque" to managers and "hidden" from the public. Thus consumer interests are represented only by proxy. Wareham (1994b) contends that external monitoring does not enfranchise the consumer but rather it adds to the providers' need to be publicly accountable. Once, the transfer of audit results to the purchaser is accepted, Pollitt (1990) argues, there is little justification for withholding such information from "responsible public representatives [eg. CHCs] and, hence, the users themselves" (p.449). Thus whilst the public may not be involved in the audit process, they have a role as agents in the accountability process.

In conclusion, Pollitt (1993) sees confidential internal audit as insufficient for external accountability. He cites the American process of separating internal and external accountability such that the former enables peer reviewed, confidential audit and the latter reassures the public and purchasers. This may be via inspectorates or Peer Review Organizations and is mandatory for Medicaid and Medicare. Longley (1993) raises concerns about the quantification of audit results and the likelihood that such information is often used for other purposes (see chapter 3). These points are echoed by Power (1993) who explains that "the tail of audit is increasingly wagging the dog of accountability and there are doubts about whether audits really empower the agents which they are intended to serve" (p.21).

The implications of purchasing clinical audit

External monitoring of provider quality poses a number of difficulties for purchasers. Quality is a multi-dimensional concept and CA forms only one part of it. Although purchasers could adopt various strategies for assuring themselves of provider quality (from ensuring systems are in place to involvement in provider inspection), Thomson (1994) recognises that external quality monitoring is beset by problems of expense, multiple purchasing agencies, poor quality comparative data and insufficient purchaser staff. Such issues reflect the difficulties of purchasers in monitoring the performance of contracts generally (Appleby, 1992).

Contracts for CA may take a number of forms including 'separate' contracts, appendices to a main contract or incorporated within sub-sections of the main contract. Separation does ensure that CA is not subsumed within general service issues but it implies audit is an esoteric activity. However, an integrated contract associates audit closely with service delivery which may dissuade clinicians from participation. An 'appendix' contract might prove a satisfactory compromise in that it incorporates audit to some extent but appreciates its distinctive function. The transaction costs of purchasing CA may also be considerable depending on the degree of involvement. The more the purchaser becomes involved in contracting for CA, the higher the transaction costs are likely to be borne by both purchaser and provider both before and after contract exchange. CA transaction costs are likely to be proportionately more than general contracting costs given the size of the respective contracts.

Funding providers' CA programmes through a contract does raise problems about relatively small amounts of money being collected from many purchasers. The proposal for a 'host purchaser arrangement' overcomes this but coordination between purchasers remains an issue (Gill, 1993, 181)(see 4.4).

Involvement in audit does offer purchasers a (new) source of data about the performance of providers in terms of clinical quality. Indeed, advocates of recent NHS reforms argue that linking audit of clinical performance to contracting is a key impetus to continuing the thrust of the reforms. "The only way through this insanity is for health commissioners to buy healthcare only from trusts which have... an independently audited, clinical performance unit - to prove that what they do works" (Roy Lilley, quoted in *Guardian*, 5.5.95, Society section, p.2-3). The purpose of this is unclear.

Purchaser strategies

Purchasers, as in other areas of contracting, have approached CA in a variety of ways, ranging from what Thomson (1994) calls a co-operative relationship to an adversarial one. These relationships are displayed in Figure 1. (see chapter 1).

The approaches displayed, though stylised, represent an amalgam covering different aspects of the purchaser's activity. For example, purchasers may take a directive approach towards the topics to be audited or funding allocation but a minimalist one to the ways in which CA results are used. Thus, at each stage of the audit cycle, a spectrum of purchaser approaches could be envisaged.

Lord and Littlejohns (1994) propose four models of "interaction" between audit and contracting, ie. isolationist, intermediate, integrated and split. These are based on the degree to which purchasing and audit have become connected. The split model separates different types of CA such that internal (clinicians and provider managers) and external (purchasers, public) parties are satisfied.

Williamson and Ouchi (1981) make a distinction between hard and soft contracting. Hard contracting involves each party remaining largely autonomous and asserting its interests vigorously. Soft contracting implies "a closer identity of interests between the parties in which the formal contracts need not be as complete" (Saltman and Von Otter, 1992, 131).

Purchaser approaches (along the spectrum identified in Figure 2) are now discussed.

Adversarial approach:

A purchaser's adversarial approach might provide information that had been previously unavailable to them except through anecdotal and subjective measures. For example, a purchaser's direction of audit topics may not necessarily coincide with clinicians' concerns. Externally-imposed topics may thus become seen as contractual obligations. Even if topics appear reasonable in the short-term, purchasers will need "to display imagination and sensitivity if providers are to be kept enthused" (Gill, 1993, 181) in the long term. Many audit topics are relatively limited in scope and so it might prove difficult to make substantial contracting decisions on the basis of a single audit even if it examined clinical outcomes. Another example of the adversarial approach involves decisions about whether to continue to contract with a provider and, if so, what type of contract that should be supported by CA information. This would be enhanced by inter-provider comparisons. It does assume, of course, that an alternative provider, with services of equal or higher quality, is able to replace a 'poor' quality provider. In many cases, this is not always possible except at the margins. Nonetheless, the threat of losing a CA contract (money)

may ensure compliance with the CA contract for failure to do so would establish a poor reputation that may have consequences with other purchasers, GP referrers and the public. This is termed the contestability of contracts.

Explicit sanctions may form part of an adversarial strategy but they may have limited use in addressing non-compliance with a CA contract. Financial sanctions may only exacerbate the problem of, for example, a clinician/specialty sceptical about audit. A more effective sanction may be an organisational one (Rumsey *et al*, 1994) which might involve closer involvement in provider audit programmes by purchaser staff such as those in public health medicine.

During the 1980s, the American Peer Review Organizations introduced a requirement that providers specify objectives for organisational performance to be achieved over a 2 year contract period (Wareham, 1994a). Like the UK, funding via contracts had replaced grants. Pollitt (1993) states that PROs have several sanctions as part of external review including mandatory re-training, monetary fines and exclusion of organisation or individual from Medicare. He notes, however, that there are "no real incentives." If purchasers were to use CA results in general contracting, they would need a high degree of confidence in those results and to be able to operate a range of discriminating incentives to encourage high quality.

However, the short-term benefits of this adversarial approach should be off-set against the long-term disadvantages. The information gained in the short-term may be beneficial to purchasing decisions but clinicians may soon 'game the system' and modify their behaviour to the incentive structure that links audit with contracting. This would militate against audit in the longer term. Furthermore, to tie contracts to CA, assuming different agenda between the principal and the agent (purchaser and provider), might only further distort the differences between the two parties. As Pollitt (1990) suggests, "the fruits of 'victory' are likely to be bitter. Resentment, reduced motivation and pervasive suspiciousness are not states of mind which a sensible manager [purchaser] would choose to promote among any group of workers" (p.442). Wareham (1994a) notes that PROs in America initially focused on detecting bad care and introducing sanctions which only alienated the medical profession.

Purchasers and providers have, so far, been portrayed as having opposite interests. It may be useful, however, to view a triad of interests involving purchasers, provider manager and provider clinicians. Thus purchasers may find allies in provider managers in addressing particular issues which some provider clinicians oppose. Similarly, clinicians, enthusiastic about CA, may find that collaboration with purchasers can introduce an issue onto the provider managers' agenda. However, this is likely to reflect other clinician-management tensions within the trust.

Minimalist approach:

A minimalist approach may be justified given the present novelty of CA to purchasers and the lack of effective purchaser strategies. It is unclear whether purchasers are adopting this approach as a proactive or a reactive stance; that is, either as a long-term strategy or a short-term response to an uncertain situation.

Given professional concerns about managerial and purchaser involvement in audit, this minimalist approach would enable audit to become embedded within a provider whilst moving towards external quality monitoring. This is especially relevant where participation in CA varies between clinicians and/or specialties. Purchaser involvement raises concerns about the linkage between audit and cost savings (contracting) and individual careers (Pollitt, 1990). The former is addressed under the adversarial approach. The latter concerns clinicians' fears that individuals may be identified. Aggregate, anonymised data may help overcome this (see 3.5 and chapter 7).

A minimalist approach means that CA remains an activity owned and run from within the trust. Although provider management may, nevertheless, take a directive approach internally, there is less incentive to incorporate CA within the mainstream trust business since its corporate interest is not at stake. However, a minimalist approach assumes, to some extent, that purchasers and providers have common interests. Purchasers may thus have confidence that providers managers and clinicians will take appropriate action following audit. This argument is probably untenable given purchaser-provider differences in roles and functions, let alone differences between provider managers and clinicians. Moreover, the contracting mechanism was supposed to be the driving force behind recent health policy reforms. However, this approach should be contrasted with the triad of interests outlined above.

3.3 Professional-managerial tensions

Some of clinicians' primary concerns about CA have centred on the involvement of managers in a supposedly professional and educational activity. In *Working for Patients* (working paper 6), audit, as an activity, was kept separate from management by statements such as "the quality of medical work can only be reviewed by a doctor's peers." However, audit's purpose was indicated by the statement: "the general results need to be made available to local management" (pp.5-6). This position was underlined by WfP's assertion that 'problem doctors' were a medical and not a management problem (Pollitt, 1993). Thus, an uncertain approach developed initially whereby managers had a limited, almost token role in (medical) audit (Pollitt, 1990). The degree of change can be noted from Ham and Hunter's 1988 paper where they indicated that audit was concerned with raising professional standards but not with the external management of doctors or doctors' involvement in management. This division may no longer be valid.

Drawing on evidence from other sectors, Power (1994) explains that audit is now central to administrative and managerial control in public and private organisations. Consequently, audit does not usually deal with primary activities such as the quality of performance of clinicians but "with the systems in place to govern quality" (p.6). Hence, Power describes audit as the 'control of control.'

Working for Patients did introduce processes that, according to Harman and Martin (1991), ensured audit could not exist as an esoteric activity in the long-term. "The purchaser-provider split will not allow medical audit to be a secretive activity in isolation from broader quality initiatives and resource management" (p.28). This reflects their view that "these are not self-contained unrelated initiatives called 'contracting', 'quality assurance', 'medical audit', 'resource management' etc.... rather they are inter-dependent and inter-related reforms" (p.30). Thus, even soon after (medical) audit was established, the potential for audit to operate in a wider environment was recognised.

A key shift in this changing interaction between audit and management was the Thomson report (1993). Although addressing the Scottish approach to audit, it identifies several key issues. Appreciating professional issues such as confidentiality and ownership, the report tackled the scope of management's

role in the selection of audit topics, the reporting of audit results, the interpretation of results, non-participation in audit and building audit into contracts. Without recommending an 'adversarial approach' between clinical staff undertaking audit and management, it does suggest a move towards closer integration. For example, in relation to topic selection, it states that

"there will also be proposals arising from unit management and from purchasers... In order to accommodate proposals for audit studies from a range of sources and to reach a consensus about the priority areas to be tackled, the Working Group recommend that an Area Clinical Audit Committee be established on which professions and management would be represented" (p.16).

As management have become more involved over time in audit, there has been an increasing recognition of the need to establish safeguards which would encourage clinicians' participation without the threat that audit results might lead to sanctions. This is what Pollitt (1990) called the need for insulation. He identified this need in relation to two aspects, viz. cost-savings and individuals careers (also see section above 'minimalist approach'). Insulation here refers to the separation of organisational procedures relating to cost savings and individual career prospects from those of CA.

In relation to cost savings, which may also include contracting here, Pollitt's argument (1990) might accept that there is some connection between audit and contracting and that additional funding to 'high' quality providers may be appropriate but only once a CA system has established itself. Separation, however, is essential at the outset.

Individuals may perceive their career prospects to be adversely affected if audits revealed the quality of their clinical performance. Moreover, such data may lead to non-clinicians judging their performance, a fear expressed by many clinicians (Rosenthal, 1995). Aggregated and anonymised data enables a degree of separation between audit and organisational processes affecting careers. Pollitt's argument suggests that the focus of audit "should be on a particular technique, service or medical firm" and not an individual (p.445). As with sanctions, rewards should not be at an individual level, Pollitt argues,

but rather at an organisational level "above the individual, though still local enough to make a difference to that individual" (p.445). Clinical directorates may be such a level.

In respect to both cost savings and careers, the forms of insulation are important. For example, clinicians on audit committees may also be (department or directorate) budget holders. This will become increasingly manifest as clinicians take on more management roles (eg. clinical directorates). (Pollitt notes that such an issue may be more acute in general practice with fundholding and the (relatively) small size of practices). It would therefore appear judicious to separate the posts of those responsible for audit and for finance from professional or general management, at least in the short term. Purchaser representation on provider audit committees may, however, pose a difficulty since this person, usually a DPH, often negotiates the CA contract also. The DPH is thus both purchaser and clinician. This impacts upon the role of the CA committee which is discussed later in this report.

One reason why the need for insulation may be less than Pollitt's argument suggest is that many clinicians have already become incorporated into the managerial agenda such that they see CA in a wide(r) context. It may be premature to say this is widespread or even common yet. However CA is requiring a higher degree of organisation and programming into other provider initiatives which raises a question about the future of a separate activity called 'audit.'

CA and the professions:

The development of (medical) audit sheds light upon the medical profession. For example, Bosk (1979) argues that audit is a way of socialising novice doctors and establishing the expectations of senior clinical colleagues. Kerrison *et al* (1994) have recently supported this notion. Their views contrast with the idea of audit as a way of challenging the medical profession.

The general ability of the profession to maintain audit as a voluntary and educational activity has been challenged but the response by the profession, soon after the publication of WfP, was to create a medical model of audit. This response involved "the profession's representative bodies quickly [setting] to work to ensure that the form of audit to be adopted would be as unthreatening as possible to medical autonomy" (Pollitt, 1993, 209). Although

neither the Department of Health nor local managers unconditionally accepted the medical profession's model for audit "neither did they appear to put up a very spirited resistance to the medical profession's bid to reassert control" (Harrison and Pollitt, 1994, 102).

More critically, the notion that the professions are self-regulating has been challenged in recent years by the introduction of audit. Preparation for this development, as shown above, has taken approximately 30 years - a strategy of prevarication, according to Dent (1993). Harrison *et al* (1992) argue that "audit is being introduced throughout the NHS not because of some sudden upsurge of interest in it on the part of rank and file doctors" (p.142) but because it is in WfP. It is, however, unlikely to signify a rapid demise of medical power but it has placed local managers in a far greater position of power than has hitherto been the case.

3.4 Clinical audit evaluation

Evaluation of audit is a relatively new activity and much of the work has only recently been published. The most extensive of these has been by CASPE Research. Initial publications included Walshe and Coles (1993a/b). These were background reports and set the context for the ways in which they had conducted their research. Two recent reports outline later CASPE research.

Rumsey *et al* (1994) summarises a survey of purchasers' role in audit, conducted in late 1993 (before the (formal) allocation of CA funds to purchasers). They structured the report into four main sections: the resources for audit, contracting mechanisms, monitoring mechanism and the future of audit.

Over half the purchasers who replied said they had no involvement in the process of allocating CA resources. Few purchasers used 'objective' measures but relied on historical patterns. Although funding was ring-fenced from Regions, a minority of purchasers did add to resources from their own revenue income. Although most purchasers were satisfied with the use of audit money, those who were involved tended to be less satisfied. Rumsey and colleagues did note the lack of consensus about what comprised appropriate spending.

They report that 58% of purchasers had audit contracts with all providers in 1993/94. These were probably undeveloped and were often part of other contracts, were not especially taxing and were not specialty-specific. Rumsey and colleagues noted that the lack of sanctions reflect the sensitive nature of audit.

Monitoring of audit was undertaken by 90% of purchasers who replied to their survey. Monitoring was largely paper-based and retrospective (eg. annual reports). Some purchasers did attend provider audit meetings and provide advice and expertise. However, most purchasers, dissatisfied with the monitoring information received, expressed concerns with details about participation in audit and the changes arising from audits.

The future of audit funding at the time of the survey was uncertain but most purchasers expected to become more involved in the allocation of audit funds. Contracting, including incentives, was the way in which audit could be influenced by them although they had yet to grasp its potential.

Buttery *et al* (1994) report on the survey (in late 1993) of providers in terms of 6 key areas: resources for audit, management of audit, the role of audit in the provider organisation, the audit department, the audit process and the impact of audit.

One third of the providers responding were part of multi-unit audit programmes but the majority had their own programme. With audit resources forming 0.25% of revenue income, many providers were underspent in recent years. In 74% of programmes, the audit committee was chaired by a consultant and the chairs were usually from general medicine (13%), psychiatry (11%), pathology (11%) and anaesthetics (11%). In 5% of committees, the chair was the medical director. The survey revealed that about 1150 (wte) audit staff were working in hospital and community health services at the time of the survey. Variations occurred in the title, grading and qualifications of such staff. Audit meetings were held in 95% of specialties but this mostly excluded non-medical staff and managers which partly reflected the traditional methods adopted.

Guidelines, protocols, clinical accountability and inter-professional working were identified as associated themes by Buttery and colleagues from the

survey. This suggests that audit is becoming well established in providers though progress varies.

Several issues affect the ways in which this and other 'evaluations' have been conducted. Walshe and Coles (1993a) identify a number of these including the various aims that audit might play. They list the improvement of quality, the control of costs, the regulation of practice, the control of technology, the control of litigation and the reassurance of purchasers and the public as aims of audit. Programmes, with varying combinations of such aims, make an evaluation highly problematic in separating the achievement of each. Whilst some more measurable objectives may be identified, these tend to relate to the process of audit such as the level of participation.

If audit is to be 'audited', there needs to be a clear justification as to why. Description of audit progress needs to be combined with analysis of whether it has achieved its objectives, what 'good practice' is emerging, what future audit funding and strategies should incorporate. Comparison with other programmes is also beneficial. Walshe and Coles (1993a) offer a structure for evaluating audit in terms of perspective (clinician, manager, purchaser and patient), level (project, specialty, provider and purchaser) and evaluation (structure, process and outcome) (p.49).

In conclusions, Walshe and Coles (1993b) summarise the evaluation of audit to date as limited, consisting of few techniques and focused on medical (cf. clinical) audit. Moreover, few evaluations, they claim, have assessed the costs and benefits of audit.

Introduction to Case Study Chapters

The next chapters focus on the empirical work conducted for this project. They mainly address the issues arising from the three case studies but use examples drawn from the survey of other purchasers where applicable. The case studies have been anonymised, an undertaking given during interviews because the research focused on the issues relating to CA and not the merits (or demerits) of selected areas. Case study areas are referred to by the letters **A**, **B** and **C**.

4. The Organisational Setting for Clinical Audit

This chapter examines the role, function and position of CA within the purchaser and provider organisations studied. The emphasis will be on the former and the latter used to highlight particular issues for purchasers.

Four main areas will be explored:

- the role of the lead officer responsible for purchasing CA
- the organisational arrangements for managing CA in the purchaser and in the provider and the arrangements for host purchaser functions.

4.1 The role of the purchaser lead officer

The study showed that the management of the CA function in purchasers involved two aspects: operational and strategic. These roles were increasingly managed by two people, one responsible for operational (day-to-day) activities such as liaison with the provider audit department and committee and the other in overall (strategic) responsibility who would be involved in strategic roles such as formulating the purchaser strategy and liaison with audit committee chairs. Sometimes these two roles were undertaken by the same person. Where it was the same, that person played a critical role within the purchaser and with the providers. That may have certain consequences as the person negotiating the CA money also has a role within the contracting process. However, no apparent difficulties had appeared at the time of the study although one DPH was also Director of Acute Care Contracting.

In purchaser B, the CA function was overseen by the DPH but managed by the Quality and Clinical Effectiveness Manager whereas in purchaser A, this role was solely managed by the DPH. In the third area, purchaser C, the lead responsibility was shifting to the newly arrived DPH from the Director of Quality, who had a role in terms of nursing and paramedical audit.

The lead officers (DPHs) saw their role as to "lead in terms of the actual direction and also the medical side", according to one of them. (Two purchasers had staff with responsibility in relation to nursing audit). Their role

and the location of audit within Public Health was usually explained by the need to link effectiveness, outcomes and audit. Another explained that she had

"the directorial lead for how we as purchasers manage clinical audit in our relationships with providers. That has two roles. Firstly, it is to ensure that clinical audit activity is linked to the research effectiveness agenda... and the second is the management of the purchasing responsibility..."

She added that the first role was achieved by membership of relevant provider audit committee and the second was administered fairly independently by her because of the novelty of the arrangements. Thus, their role was to build relationships with providers and to place CA in a wide context, one that was more linked to clinical effectiveness and outcomes rather than explicitly managerial and contractual issues. Their role did not usually extend to the audit undertaken by Public Health doctors, as clinicians, within the purchaser.

The DPHs were not always members of provider audit committees. One who was also sat on the MAAG, thereby ensuring she was the only person to oversee the approaches locally. This breadth of vision was welcomed by providers and the MAAG. However, she recognised that she played a dual role as purchaser and Public Health doctor and felt that she had probably been invited to attend meetings as a purchaser. Another DPH had more intermittent links with providers and generally left it to the project support manager for CA. There, purchaser representation on the audit committees (requested by the chairs) was not always realised. That purchaser tended, however, to use more informal liaison mechanisms. One DPH, rather than sitting on a provider committee, had instituted a district-wide audit group involving the chairs and facilitators from each of the three local providers (see 4.2.). In addition, she planned to meet independently with the audit committee chairs for "regular updates of the audit we are contracting for so that we have good feedback..."

4.2 Arrangements for managing clinical audit in purchasers

Rumsey *et al* (1993) found that 90% of purchasers located their CA responsibilities in the Public Health Department but all South and West Region purchasers managed their responsibility thus.

Purchaser staff and audit teams:

Although many purchaser staff claimed to know little about CA, a key feature of two of the purchasers studied (A and B) was the way in which other members of the purchaser staff were increasingly being involved in the CA (contracting) process. This was a general move towards seeing audit in a wider context. As one person said

"One of the important things [in this purchaser] is not to have public health to clinician discussions which don't link with the contracting team."

Another, from the same purchaser, explained that

"It's part of the style of this organisation... there's quite a strong push not to have separate things that ought to be part of the main contract negotiations."

Two purchasers (A and B) had established small teams within the organisation to draw together particular skills such as nursing, finance, contracting or primary care. For example, the CA team in purchaser B first met in July 1994 when it discussed audit finance, a model contract for audit and the topics to be audited. The Quality and Clinical Effectiveness manager explained that the team's "way of working is not so much to run CA but to act as a sounding board and discussion point." The group would thus set the strategy and the relevant managers would act upon that advice. The team meets bi-monthly. The team's way of working arose from the organisation's style, as described by one of the team's members:

"One of the things in this organisation, the distinction between what your job title is [and the task performed], tends to be blurred. People tend to get selected because they've worked together well or offer something generally in terms of approach."

Thus, CA reflected the way in which purchasing was evolving. This underlines a view advanced by many purchasers that CA needed to be integrated more closely with the purchaser's business. One such opinion (from purchaser B) was:

"...what happens in clinical audit in terms of where it's linked in with clinicians or whatever can often be a reflection of what's happening in the rest of contracting or commissioning. It's a symptom rather than a separate issue."

Involvement of the contracting department:

The degree to which contracting departments have been involved so far in the purchaser's CA strategy was variable. These degrees of inclusion were justified by the embryonic nature of the CA function in purchasers and the need to respond to the local context (such as the development of provider audit programmes). (For further discussion on contracting and CA see chapter 6).

The 'inclusion' of contracting in CA functions consisted of contract managers involved in purchaser audit teams or contract managers negotiating the CA contract with the providers. Purchaser A involved two contracts managers in the purchaser team although the lead officer proposed CA should be separate from the main contract. Their inclusion arose from the CA contract, as one of them outlined:

"I think we were brought in because we were drawing up another contractual agreement... Again because it [negotiation] is likely to include people within the trust who have a similar view of contracts, there was a contact there. It wasn't because of our knowledge of the trusts first and foremost."

The CA contract, meant "that we didn't hugely change what we were doing with CA. We just agreed the money was ring-fenced and that... we would not be about... driving it a very central way" explained the other contracts manager.

In purchaser B, contracts managers were not involved in the audit team (though some thought they should be) but in the contract negotiation with providers. One manager felt that

"There was a disadvantage because I sign the letters which have been talked about by other people. That's OK as long as people appreciate that for detailed questions [about CA], I'm not the right person to talk to."

In favour of their inclusion, he argued that

"If you don't involve the main contracting team of the provider unit, it will be done by staff here [in the purchaser] with the head of the audit committee and not seen as a very mainstream activity within the hospital."

He explained that his views were based on the previous year's experience with one of the local trusts, when CA was promoted as a separate activity in the main contracting negotiations.

In purchaser C, which had not 'included' (by accident or design) contracting managers from the internal CA processes, the CA contract was managed by the lead officer, responsible for the 1994-95 programme. She described the process of negotiating the CA contract as independent of the contracting managers or department.

"I wrote a clinical briefing for them - it was for the preparation of contracts we agreed last April... It was my stab at giving it a profile and a focus in the contract documentation and letting the providers know."

Although she described this process as "basic" and "simple", she felt that, in two or three years, a more detailed contract would be required. This may entail a more direct involvement from contract managers.

Monitoring of CA contracts were usually undertaken through informal mechanisms by the CA project officer, though sometimes also involving a contracts manager in some purchasers.

District-wide audit groups:

In purchaser, C, a small district-wide group had been established by the DPH which comprised the purchaser's Director of Quality and the audit committee chairs and facilitators of the local providers. The DPH explained that the role of the

"committee is to discuss the principles, the contractual issues, to discuss the financial issues, to discuss timetables and forward

programmes... So that committee is looking at the more strategic strands of audit and the local trust audit committees are looking at how that translates into operations within their own trusts."

One person who sits on that committee welcomed the purchaser's approach by saying that

"The way the purchaser is doing it here which is getting people together, having an open discussion, looking at the ways forward so it feels like a joint venture. That message needs to infiltrate every corner of those providers... At the moment, it is about establishing a joint agenda."

This quarterly meeting was in addition to a series of individual meetings that the DPH planned with committee chairs (see 4.1.).

4.3 Arrangements for managing clinical audit in providers

Parallels can be made between the provider and purchaser organisations especially in terms of how professional and managerial responsibilities for CA are discharged.

Managerial and professional responsibilities for CA:

Management of CA has taken a number of forms including the separation of strategic and operational functions. The operational functions have usually been managed by audit facilitators and the audit committee. However, with the incorporation of nursing and paramedical representatives and the mainstream role that audit increasingly plays within trust, many providers have responded by establishing a small strategic group. This usually consists of the committee chair, the facilitator, a (contracts or quality) manager and other key staff. This group specifically addresses the issues of contracting. One facilitator indicated why they should establish such a provider group:

"What we need to do is form a sub-committee, a small group of four to make the real decisions about which direction we are going in. That can only be done by the people who have got the feel for it [CA] throughout the hospital."

In all but one of the 7 providers, the chair of the audit committee was a consultant. (Buttery *et al* (1994) found only 3% of the committee chairs in their sample had non-medical backgrounds). The background of the chair has implications for the increasingly managed nature of CA and the uses to which it might be put by the provider and the purchaser. In one provider, the professional and managerial responsibilities of CA had been split:

"Supposing we have a disagreement about something, he is the chair of clinical audit [committee], I'm managerially responsible for clinical audit. There were some questions raised... about potential conflicts."

This manager was a trust board member which gave some influence and profile to audit because, according to the facilitator: "...managerially she can ensure that those action plans [arising from an audit] are followed through." By contrast, in purchasers, DPHs combined professional and managerial roles.

Another provider in case study (C) had a non-medical chair of the audit committee. The chair, also a trust director, remarked that

"What was interesting was that it was totally accepted that I would chair it [audit committee]... I report to the board and manage the whole thing... It is political for it to be described as working in partnership [with the Medical Director]."

The acceptance of a non-medical chair may have been partly because that trust did not previously have a well developed audit function and was not oriented towards acute care. According to the audit facilitator there, this organisation of audit was beneficial since "I am viewed very differently than I have been in the past.... to have that support and clout [of a trust executive] is wonderful."

One audit committee chair (in the same case study area) accepted the need for managerial input in audit but questioned whether it should also be someone who held professional responsibilities. For as he argued, the professional with managerial roles "can pretend to be a professional but is acting as a manager and the opportunity for conflict is just enormous."

Multi-trust audit programmes:

Multi-trust (medical) audit groups were found in 116 of the 325 trusts (36%) surveyed by Buttery *et al* (1994). Acute and community services were the most common combination of such groups. One such group was manifest in case study A. There, two trusts ran a single audit programme, an arrangement which one person involved described as "strange." She added that

"the original proposal was that the power base should be with the district one [committee] and what I've managed to do is get that turned on its head."

This was needed, she felt, because there were no cross-trust audits taking place. The audit department of the larger trust was managing both programmes. However, another person from the same provider unit was "keen to keep those links. It seemed logical as we treat the same patients - to have that ability to structure audit across the whole patch." These difficulties arose partly because one trust was relatively small and previously unable to support an audit function. In other areas (eg. B), small trusts have begun to develop their audit capability often with additional money and/or assistance from the purchaser. As audit becomes increasingly linked to trust business, audit programmes relating to individual trusts may become more likely.

4.4 Host purchaser arrangements

The model proposed in EL(94)20 was the host purchaser arrangement whereby (DHA) purchasers would contract for CA with providers located within their geographical boundaries even if they also contracted for services with providers beyond those boundaries. Whilst nearly all attention is focused on the host purchaser and 'local' providers, there is an important additional dimension, one which involves the ways in which purchasers promote, manage and use CA in non-local providers. The case studies provide contrasting approaches.

Purchaser B took an approach which had not really addressed the CA in those providers with whom the purchaser had a contract for services but which were located outside the purchaser's boundaries. The lead officer recognised the lack of such specification and the associated difficulties:

"But there are problems with different purchasers wanting different things. And the line we've taken at the moment is that the other purchasers will set the main agenda but if there is anything we particularly want... then we would expect to give money [to that provider]... to do an audit to our agenda."

This was quite a direct approach to the host purchaser arrangements but had yet to be put into practice. The money would go to the provider and not necessarily via the respective purchaser or on a recurring basis. Liaison with other host purchasers was on their agenda but this, she felt, was not an audit issue per se but rather "across the whole of purchasing and again it's about not taking audit out as a separate issue."

In purchaser C, the process of agreeing the CA agenda with other host purchaser involved the circulation (to neighbouring purchasers) of the draft audit programme agreed between purchaser and providers. This would ask the host purchaser for comments or additions. The lead officer (C) did, however, explain they were not expecting many additions. Her colleague did argue for further clarification of this arrangement especially in terms of timetables for CA projects and areas for re-audits. Interestingly, the lead officer did add that she would expect to establish CA contracts with independent and private sector providers, not just local NHS providers.

Two key policy areas have and will emphasise still further the importance of effective host purchaser arrangements: comparative audit and GP fundholding. Comparative audit will be necessary with neighbouring providers as some purchasers had too few providers for effective comparison. This will necessitate negotiation with other host purchasers and/or those other providers. As one person indicated above, this should be part of a strategy of dialogue between purchasers anyway. Difficulties may arise, however, when negotiations take place outside that arrangement, ie. one host purchaser funds (or does not fund) CA in an ex-district provider without consultation with the respective purchaser. Difficulties as outlined in EL(94)20 may be encountered especially if a specialist service negotiates with several purchasers.

Fundholding is different in degree from host purchasing since it is the host purchaser that must purchase CA on behalf of the fundholders located within the 'DHA's' boundaries. Therefore, the DHA and GPFHs must have channels

of communication to facilitate a joint agenda both locally and with ex-DHA providers. This issue has been briefly addressed in the GPFH Accountability Framework (published April 1995). Difficulties might arise as GPFHs are more perhaps likely to contract with non-local providers. (GPFH and primary care audit are addressed more fully in chapter 8).

4.5 Conclusion

The ways in which purchasers organise their responsibilities for CA provide messages to provider clinicians and managers. Although a spectrum of approaches was initially envisaged, this notion become obscured in practice because both similarities and differences were identified between purchasers. Similarities included the lead role for Public Health, the formation of strategy groups (either within the purchaser or in conjunction with providers locally), the increasing division between strategic and operational aspects of purchasing CA and also the lack of mature host purchaser arrangements. This latter point should be tempered by the recognition that 1994-95 was the first year in which purchaser had responsibility for CA and attention was largely focused on their host providers. Nevertheless, all purchasers and providers involved in the study were structuring their audit functions in a far more systematic way than hitherto had been the case. Differences included the degree of involvement of a wider group of purchaser staff (eg. contracts staff), the degree of interaction between 'audit' staff in purchasers and audit staff in providers, the extent of incorporation of senior trust staff in provider audit and the dominance of CA committees by clinicians, especially medical personnel.

The organisation enables the purchaser to adopt strategies ranging from directive to one of minimal involvement with respect to contracting for CA. Aspects of these strategies will be discussed in the next few chapters.

5. Clinical Audit Topics - The process of selection

This chapter examines the process of selecting topics to be audited. The selection of topics is one of the first stages of an audit process undertaken by clinicians and, in turn, it is a critical area of involvement for purchasers.

Three main areas will be explored:

- the process by which purchasers select topics to be audited
- the degree of prescription that the process entails and
- the process by which providers select topics to be audited (either unilaterally or in response to the purchasing process).

Topics selected by purchasers reflects their priorities and so the process is one of the stages in the audit process when purchasers may exert a degree of prescription over providers (see figure 2). However, this process of selection is different from that operated within providers and it does not comprise the complete list of topics that a provider undertakes to audit that year. All purchasers have left room for local discretion and choice, as proposed in policy guidance (see chapter 2). In general, purchasers have not been especially specific in 1994-95 in the topics selected for audit but have indicated broad areas of concern. This initial approach has helped to establish the process of topic selection as a legitimate area for purchaser involvement and intimates future approaches.

5.1 Purchasers' process of topic selection

The analysis of purchasers' selection of CA topics can be classified in three sections: who is involved, how are topics selected and which topics have been selected?

Who is involved?

The question of who is involved in selecting audit topics is crucial in determining the degree of ownership which clinicians feel in undertaking audit and, where appropriate, changing clinical practice.

The process of topic selection by purchasers has tended to involve a small group of purchaser staff, principally overseen by the lead officer for CA.

Those involved have tended to be included in the purchaser's organisational approach to contracting for CA, either through the audit team (as an adviser) or as a project manager of the process.

Purchaser B used their purchaser audit team to "sift list of ideas from people in [the purchaser] and prioritise" (from purchaser team meeting's minutes). Indeed, this process was seen as one of the team's key tasks, viz. to "set the clinical audit agenda working with provider clinicians, other purchasers, GPFHs and GPs" (Business Plan 1994/95). This process thus gathered a range of information from various sources. According to one member of the purchaser's audit team, the selection of topics was a key task of the team.

"We've been very much focused on what areas we should undertake audits in rather than discussing the philosophy of audit..."

In purchaser A, like others, this year's process involved the selection of key areas of concern, identified by the lead officer alone. She explained that

"Last year I decided them [the topics] and that was legitimate because they were wide topics, they were non-contentious..."

How are topics selected?

Purchasers employ a number of different strategies to select the topics to be audited. Most have followed the Regional guidance of '40-40-10-10' equating to the (percentage) breakdown between purchaser topics, provider topics, regional/national topics and inter-agency topics respectively. Although the guidance did not specifically state whether these percentages related to the funding, number of topics or time involved, purchasers and providers have adopted the 'spirit' of the guidance that gives purchasers a legitimate voice in the process of topics selection. Essentially purchasers have adopted three main ways of topic selection, viz. unilateral decision by the lead officer(s), audit team/committee decision and through specific approaches. Usually a combination of approaches is adopted. (The first two have been outlined above).

Specific approaches describe processes consisting of a number of ad hoc arrangements but indicate the potential of a more 'rational' approach in the future which will be in a framework of key topics areas such as 'Health of the

Nation.' One person described the essential topics areas combined with an imprecise process:

"There are always 'must-do's' like prescribing but I feel we are trying to cooperate... It's [the process of selection] horribly informal, I guess at the moment."

The approaches include suggestions/issues raised by GPs (especially GPFHs) and provider clinicians, service complaints, contract monitoring and service reviews. One purchaser manager (C) described the need to keep "a running list" of topics throughout the year from these various sources. He clarified this by saying:

"Subjects for audit are coming up through the whole planning and review process, through the complaints process... and through the more enlightened clinical directorates in our providers saying 'we would like you to fund this piece of work.'"

These approaches are designed as much for identifying topics (which may be discussed by the purchaser audit team or chosen by the lead officer) as accepting them as uncritically. Although this was a largely a reactive process, it did not preclude consideration of other topics. Negotiation and discussion of topics featured in all case studies. One purchaser (C) summarised their process thus:

"So we identify the topics that we are interested in and discuss it with our providers and also with our GPs."

A provider manager from the same case study area felt that purchaser-defined topics represent the "biggest shift" in audit over the next few years but basically endorsed the purchaser's ability to negotiate topics:

"Whilst it is important that purchasers influence the topics, I think they must also do that by discussion and debate with providers because you will not get such strong commitment and therefore such clinical involvement in the audits unless it is something jointly recognised."

The nature of negotiations is discussed in section 5.2.

Which topics are selected?

The topics actually selected helps assess the use that might be made of audit results. The types of topics selected by purchasers addressed many different aspects of purchasers' responsibilities and reflected policy issues, clinical advances, audit and purchasing developments. One purchaser (**B**) included 5 "general topics" in their draft audit programme:

- "audits relating to clinical effectiveness...
- care in the community related audits
- audit projects related to Health of the Nation
- joint audit projects with primary care professionals
- audit which develop the involvement of non-medical health care professionals"

Some topics were deemed legitimate whereas others were contested and had to be justified more carefully. For example, some were critical of the approach which necessarily accepted topics based on the 'Health of the Nation' when the quality of the audit proposed was poor.

"I can show you some of the bids [ie. audit proposals]... [that] got through - vast sums of money for audits that aren't particularly good audits but they are 'Health of the Nation' targets so they got fully funded... It's only the topics they [purchaser] go for."

The level of specificity of topics that purchasers selected was general in nature; that is, broad areas of concern rather than specific aspects of services. Purchasers were obviously wary of specifying topics that challenged clinicians too much in the first year. The purchaser above (**B**) also produced a list of "specific topics" which included:

- "smoking in pregnancy
- deaths in hospital of patients under 35 years old
- outcomes for joint replacements
- use of aspirin and transient ischaemic attacks"

Even these more 'specific' topics were general in nature, leaving room for local discretion and negotiation. One provider clinician (in a different case study area (A)) indicated that, through negotiation, broad topics (like those above) were refined to make them applicable and acceptable to his clinical colleagues:

"...the purchaser indicates to us areas where audit is desirable from their point of view. They tend to be on much broader issues I would have to say than departments tend to initiate on their own. We would then discuss it, sort it out within the trust and we'll have discussions long before there is anything formal contract..."

Rather than specifying the topics headings, some purchasers stated the number of topics that providers should address. This device is designed to ensure the greater participation of clinicians without being too directive. Usually the number of topics per specialty or clinical directorate is specified. In purchaser (B), one person explained that the number of topics included in the draft audit programme (which amounted to about 20) was not definitive.

"We weren't saying that we wanted all of them to do all of them. These were areas we would wish to see looked at... I'd rather they say 'we will choose 3 or 4 of those topics and do long term good audits.'"

Another purchaser (C) expressed her organisation's reluctance to specify too many topics:

"I don't think we would want to put too many topics into that arena [audit programme] except ones that we had highlighted through service reviews or national or local research."

Purchaser's advice was mirrored by providers, especially the audit facilitators. Though not with purchaser's advice in mind, one facilitator presented her approach to clinicians:

"What I am saying to them is that I don't want you to do so many audit projects. I only want you to do 2 or 3 a year but come up with some outcomes or include a re-audit."

One trust executive in another case study area (A) argued that providers would welcome fewer, more focused topics identified by purchasers. Describing a possible purchasing approach, she said

"I would be looking for a contract that might say 'we have a particular interest in 1 or 2 issues and we would like to do some work in this area. Here's the rest of the money to enable you to do some bottom-up work.'"

5.2 The degree of prescription in purchaser topic selection

A theme running throughout this project is the degree of prescription that purchasers might seek in purchasing clinical audit and this would apply to the topics selected for audit.

The evidence to date of prescription by purchasers is heavily contingent upon the first year of their responsibilities for CA. As mentioned earlier, the '40-40-10-10' balance has been widely accepted, based on an understanding that purchasers have a legitimate role in shaping local CA programmes. One CA committee chair saw the reasons behind the division:

"I can see what is driving it - giving everyone a fair crack of the whip but whether it means anything at a particular local level... That 40-40-10-10 representing 'x' amount... - that split maintains the artificial nature of those barriers... That should not really be the finance, it should be the representation and the commitment to an audit committee which is agreeing an agenda."

However, by contrast, one facilitator related one consultant's reaction to the purchaser's involvement:

"He said on seeing this [purchaser's] list 'I thought we weren't going to let the purchaser dictate what we were going to do.'"

The first year's experience of specifying the 40% 'purchaser allocation' was mostly indicative rather than prescriptive. One DPH described their approach to topic selection as "non-contentious" and "not constraining." She felt that her purchaser's approach was "less prescriptive than many others" which, she felt,

enabled a higher quality of audits to be conducted. This higher quality was preferential, she argued, to a higher level of control over the process. The chair of a CA committee in another area (C) agreed with such an argument. He described the first purchased audit programme as "fairly uncontroversial which is probably the right way to start."

The degree to which purchasers will become prescriptive in specifying topics in subsequent years is more problematic. Opinion was more divided on future approaches. For example, one purchasing manager (C) explained that

"We don't want to dabble if it's [audit] happening. We will only come and be prescriptive if they [clinicians] are not doing it."

However, she later revealed that

"I think in 2 to 3 years time we will have a very specific contract which will talk about the topic areas and the repeat areas."

One CA committee chair from the same area explained that purchaser's degree of prescription will depend on "how the purchasers wish to use audit in the future." Although another chair (in case study area, B) thought that purchasers would not become more prescriptive in future, the chair of another committee in the same area argued that the more that topics were agreed between purchasers and providers in a forward plan, the more that the CA allocation should be passed to providers "automatically." This is in contrast to one purchaser manager (B) who felt that as the (percentage) allocation "unwinds", "we will begin to see a lot more funding for specific audit topics." Purchasers will in future need to prevent what one CA chair called 'battle fatigue' - that is, the perception of growing prescriptiveness by purchasers and the need to continually enliven the audit process. Re-audit topics may be one area where 'battle fatigue' sets in, unless purchasers are sensitive to clinicians' concerns and propose imaginative solutions. Since some clinicians chose audit topics which are 'new problems', re-audit involves the repeat of earlier work. Another chair felt that, if topics were too prescriptive, clinicians would become mechanistic, militating against long-term change.

A critical area in the degree of prescription regarding topics is the balance between an agreed agenda (whether purchaser is prescriptive or not) and room left for local initiatives. Many people in this study felt that such a balance

should be pursued although some were unsure about how it might operate in practice. This reflects a balance between 'over-simplified' and 'over-complicated' questions posed by purchasers. Thus, topics need to be relevant to purchasers and yet of interest and meaning to clinicians. Given purchasers' lack of previous involvement in CA, the ownership of topics by clinicians should be considered. Indeed purchasers recognise this. One purchasing manager (C) explained how they ensured the programme is relevant and secures ownership:

"I don't want to be too prescriptive. We would rather put it the other way round - to ask the trust to produce their programme for our perusal. If they satisfy us, it's much simpler coming from them because they are likely to own it and achieve it but, having said that, keep the proper tension and relationship there; we will be putting topics in anyway."

5.3 Providers' process of topics selection

Although this study did not specifically address the ways in which providers selected topics for audit, evidence was gathered that inform this process.

Until recently, clinicians had 'control' over this process including the option not to audit. But latterly a wider group of people have been involved, eg. trust management or purchasers. For example, some programmes involve the CA department in a process of rating proposals for audit assistance. One audit facilitator stated the audit committee's role in that process:

"Instead of sitting and listening to what has been happening, they now have to take part. We now assess all audits which they have to do and filter back to the meeting. I devised a form for assessing audits, trying to prioritise them."

A member of that provider's audit committee clarified this assessment process. The criteria for deciding whether the CA department should support an audit included the degree of patient focus, the expected improvement in patient care, the involvement of other clinical disciplines and the quality of the audit proposal. Other providers have used similar criteria such as services with high costs, high volumes, high patient risks, patient outcomes and/or new service

developments to provide audit assistance. Thus, providers supported projects on a case-by-case basis. According to Buttery *et al* (1993), 60% of providers surveyed used some form of criteria to decide which projects to support.

A number of CA committees had taken a degree of prescription in managing CA in the provider unit. For example, some had specified that each specialty should identify a certain number of topics each year. In case study area (C), one CA facilitator explained the provider's approach:

"We have asked them [directorates] all to provide us with 2 major audits for '94... We said at least one must be clinical [audit]."

This reflects the statement of a colleague on the CA committee to the effect that "we now have had our audit programmes negotiated with each directorate over a number of years... At the moment, it is very much provider-driven." These changes imply a transition for CA committees towards a role of management and coordination of audit, rather than just its administration. However, one committee chair described its role as a "buffer zone" between clinicians and purchasers.

A significant finding of this study was the ways in which topics selection in providers was being increasingly 'managed' by the CA committee/department or trust management bodies such as clinical directorates. As indicated above, directorates (rather than individual clinicians) were being asked for the topics they would be audited. One provider unit involved in this study was trying to establish audit groups within each directorate and to ensure that service developments were linked into the audit process. This evolution recognised the coordinating role of the CA committee but also its limitations in connecting the products of CA with general provider initiatives. Another provider had asked for audit topics to be linked with directorate business plan objectives.

5.4 Conclusion

The selection of topics for audit represent a critical area of contention in the ways that purchasers engage with clinical audit and providers. To ensure that the purchaser's role is seen as legitimate and beneficial, they need to consider ways in which they can raise reasonable issues with providers that will be of

benefit to purchasers and providers. The study showed how both parties were entering into negotiations to refine initial audit areas into manageable questions. Inevitably some topics were given greater priority than others, were more detailed and/or were jointly agreed. Thus, although some purchasers were relatively more directive than others, for the most part purchasers had yet to be fully prescriptive about the content of topics to be audited.

Purchasers' process of selecting topics involved a small group, drawing potential topics from a wide range of sources. though mostly reactive, this proces was becoming much more structured. Likewise, providers, in the form of CA committees, were increasingly managing the process. Sanctioning support from the CA department was the main way in which they managed the process. Topics chosen by purchasers were general in nature and allowed scope for discretion locally. Thus, purchasers were not that prescriptive in this respect and they will need to exercise caution in future years to maintain the participation of clinicians whilst, at the same time, meeting purchasers' aims.

6. Clinical Audit Funding, Contracting and Contracts

This chapter examines the financial and contractual aspects of CA arising from purchasers' responsibilities for the allocation of CA funds. As the responsibility is largely a financial one and given the influence of finance, purchasers' roles have implications for other aspects of the purchaser-provider relationship, described elsewhere in this report.

This chapter is divided into two main sections:

- the funding arrangements and
- the contracting process

6.1 Funding arrangements

Funding levels:

Nationally, between 1989 and 1994, the "funding allocation" to medical (HCHS), nursing/therapy and primary care audit was £220.7 million (EL(93)59). From a figure of £28.0 million in 1989-1991 to £41.9 million in 1993-1994, the "medical HCHS" audit funding allocation increased by nearly 50%. In Annex A of EL(93)104, the figure for the "total clinical audit 94-95" is £39.664 million which represents "the sum of each regions 1993/94 medical audit and nursing & therapy audit allocation adjusted to reflect the resident population share plus a share of the additional £2.2 million" to promote clinical audit.

Each Health Authority / Commission in the South and West Region received approximately £430,000 each in CA allocations in 1994/95. This ranged from £114,000 for the Isle of Wight Health Commission to £737,000 for the Bristol and District Health Authority (Avon Health) (Wessex RHA letter, 1.2.94 and CA Department, South Western RHA). These figures equated to 1994/95 (recurrent) allocations to providers of, for example, £105,000 for the Poole Hospital Trust and £172,000 for the Royal Devon and Exeter Healthcare Trust. However, these figures represent small percentages of the Authorities' / Commissions' overall allocation. As such, one lead officer for CA (purchaser B) thought the funding level was

"not a massive amount for a trust but for an individual care group that gets it means that they can do a piece of work. Even £1000 means that they can employ audit assistants to do a piece of work that otherwise they wouldn't have the capacity to do."

This view contrasts with one clinician who thought the amounts implied little influence, ie. there was

"Not enough money anyway to have enough bite. Our [provider] budget is £65 million. £100,00 [for CA] is not huge. That's why I think a lot of providers will give two fingers to the idea that the purchasers will influence the audit programme.... it's such a small amount of money that most of the audits that are being done are not being funded by the purchaser."

Buttery *et al* (1994) indicate that CA funding represents 0.25% of a provider's revenue income.

Purchasers have generally allocated the amount they received from the Region to the providers, with the provisos outlined in chapter 2. Some purchasers involved in this study indicated that they might consider the funding level devoted to CA with a view to varying the overall amount allocated to providers from year to year according to the exigencies at the time. One lead officer (purchaser B) explained that 'her' organisation might review the amount devoted to CA. Another purchaser manager (C) elaborated this point more fully:

"I think we would always want to clearly identify what we are spending on audit or what was being spent and reserve the right to adjust that amount if we felt we were not getting good value... There needs to be conscious decisions about audit investment. I could see a situation where that goes up and down according to the identified need for the work."

What is purchased - individual audits or infrastructure?

What does the audit allocation fund? How much freedom do purchasers and providers have in changing the patterns of expenditure on clinical audit? Questions such as these lie behind the concerns with the balance between

funding the infrastructure of the provider's audit programme and the earmarking of finance against individuals audit projects.

Historically, audit funds have been used to establish audit departments in terms of staff salaries, computers (hardware and software) and training. It has not usually been used to fund clinical time to cover clinic sessions or locum cover. (CA committee chairs receive sessional payments to cover their input). Hence, CA allocations do not cover all the audit taking place within a provider but rather has, in the past, funded the infrastructure costs. Purchasers and providers in the study recognised that, in the short term, it was not possible to alter this traditional funding pattern but purchasers questioned whether it should be maintained in the future. One provider manager reported that audit staff expenditure amounts to about 75% of the total allocation which involves "quite an investment in training people and getting the right level of skill" although she conceded the deployment of audit staff may vary over time.

One lead officer in purchaser (C) indicated how the allocation may be allocated in the future. She recognised the need to support the existing infrastructure:

"...a lot of the existing audit monies are used in audit departments as support. We recognised the need to safeguard that for the security of those departments.... [but] we might choose to use some of that [allocation] to enhance the general clinical audit budget or it might be that we agree the baseline clinical audit committee around the contract but for really good innovative pieces of work around outcomes, we have got a separate pot that we can invest in."

A clinician in the same case study area felt that the outline described above may be preferable:

"It would probably be better if it was all devolved into individual departments and there was a small core resource for advice on audit techniques..."

The allocation designated for specific topics would, according to one lead officer, encompass purchaser-selected topics:

"We may not commit all our money for purchaser audit with the trusts. We may keep some aside because we may actually want to buy into audit on a particular topic."

The general view expressed in different case studies areas was that a structured allocation will develop whereby a proportion secures audit infrastructure and the remainder is designated to specific projects or areas. Funding would thus become associated with audit contracts by specialty but would need to ensure that other specialties did not suffer as a result in accessing audit resources. Essentially this is a process of balancing risk. Whilst, it would give purchasers greater flexibility, it makes provider's funding much more conditional.

Recurring and non-recurring allocations:

Underlining some of the infrastructure issues is the balance between recurring and non-recurring allocations. One purchaser (B) had taken a prescriptive approach to this issue by allocating 50% of the 1993/94 allocation to providers for 1994/95 only and the remaining 50% for 3 years. The 50% figure relating to one year was represented by 40% (of the overall allocation) of the "purchaser choice" and 10% by "community/primary linked audits." The 50% figure relating to 3 years was represented by 40% of the "provider choice" and 10% for "regional/national audits." This arrangement was agreed at their first audit team meeting in the summer of 1994. The idea underlying this approach was that the purchaser would have some flexibility in the short term and that providers could be reassured (for 3 years) that some funding was guaranteed. The lead officer explained the policy:

"50% is 'go away and do audit. It would be nice to hear about it.'
The other [50%] is on the specific issues from purchasing intentions."

This approach was facilitated by an uplift in funding between 1993-94 and 1994-95.

Several purchasers expressed the medium to long term uncertainty about CA funding which, they claimed, explained their cautious and generally non-prescriptive approach. However, some were using their allocation in innovative ways. For example, the funding uplift in 1994/95 from 1993/94 was used in purchaser B as a pool of money against which providers (both

within the purchaser area and beyond) could bid. Bids would be accepted according to purchaser topics. Assuming providers can support a department from baseline funds, it is unclear what the bidding process actually purchases. The core staff are already employed and it is difficult to increase the staffing in the short term. The bidding process may, however, be used to focus providers' minds on specific topics and ensure their compliance with the purchaser's agenda. As one purchaser explained

"...from our perspective, if you sink all the money in on a recurring basis to set up an audit team [department], you've got less control and influence and leverage. I would want to retain some of that."

Another described this process as "getting a foot in the door." However, the risk lay with the CA department and not particularly the clinicians, as one provider described:

"That lever is because the auditors... will be running round like headless chickens trying to get bids in to secure the rest of the money."

An associated issue here is the 'ring-fencing' of audit monies. Although the NHS Executive allocation of CA funds will no longer be ring-fenced from 1994-95, most purchasers have continued to carry forward their unspent allocations in subsequent years. (This figure represented 19% of MA monies in 1991/1992 (Rumsey *et al*, 1994)). One project officer felt that the existing system of purchaser ring-fencing CA money should continue for a while until further evidence was available.

"I would personally argue for keeping it ring-fenced at least for next year because people are establishing clinical audit. I think we would want to be in a position where we've had enough experience ourselves to know whether what we're doing in clinical audit... was useful before we talked about shifting anything."

This view was echoed, indirectly, by some providers who felt that they were still in the early stages of establishing CA within their trust. Purchasers, aware of this, were thus keen to ensure that "funding is ring-fenced and is therefore protected from some of the cost pressures trusts are facing."

Future funding arrangements:

Many of the issues arising above imply that the future funding arrangements for CA are likely to be uncertain. Whilst some claim that CA money, like other ring-fenced allocations (eg. AIDS allocations), has been mishandled, an uncertain future is likely to be accompanied by the need for greater clarity and purpose, expressed by purchasers and providers. Purchasers are aware that they need to be moving towards a position of conditional funding which some providers also favour. They need to ensure that CA allocations are not spread too thinly between or within providers and, at the same time, create a framework that does not produce perverse incentives for clinicians or audit facilitators. However, all purchasers' approaches were cautious, allowing policies to emerge from experience of managing allocations. Many purchasers would review expenditure on audit in future years and some thought that allocations to providers might increase, if particular topics were considered important enough. Many of these decisions would, purchasers claimed, be dependent on a demonstration of the 'effectiveness' of the CA expenditure.

The future of audit is considered more fully in chapter 9.

6.2 Contracting for clinical audit

This section focuses on the contracting process for CA, the formulation of contract specification, contract monitoring and the incentive structure (rewards and sanctions) that may be imposed as a result of the CA contract. It is important to remember that most purchasers had not contracted with providers directly for CA until April 1994 and since then, some have only developed cursory ones. However, the existence of a contract is the formal process by which purchasers will shape the nature of providers' CA programmes in future. The pros and cons of the type of contract (separate, appendix or within the main contract) are outlined in chapter 2.

Formulation of contract specification:

The individuals involved in this process held similar posts in each case study. Generally the lead officer (the DPH) or their delegated project manager negotiated the contract with the provider. However, one purchaser undertook this task largely single-handedly whereas another involved contracts managers also. The individuals involved were appropriate to the purchaser's aims and context. For example, a purchaser who had taken a minimalist approach in the

specification of the CA contract, adopted a "fairly independent approach." By contrast, for the purchaser who had involved contract managers, the (long term) aim had been to involve the contracting team of the provider unit, according to one purchaser (contract) manager. Contract managers' involvement in this or other purchasers does demand that they become integrated into the purpose of audit in the same way that they were hoping audit would become integrated into the mainstream of provider business. This would mean involvement in, for example, the purchaser's audit team. In one case study area (A), this was already happening but this was "to make sure there was some continuity across the trusts", according to one such manager.

Although EL(94)20 proposed a 'block contract' model for CA, the specification of the contract varied between purchasers in this study. Given the leeway permissible in this Executive Letter and other policy guidance, this is not surprising. The only commonality among purchasers was the general lack of detailed specification. The model contract had proposed headings of the definition of audit, objectives of the contract, a framework for CA activity, "support staff and facilities", "monitoring performance", "payment" and the "contract management group." for the most part, purchasers shied away from including specific elements within the contract. Examples from the case studies illustrate this point.

In purchaser (C), the lead officer who had been responsible for the 1994/95 contract commented how

"The contract they have signed up to is: they will produce a clinical audit programme to our satisfaction."

So the form of the contract was related to the production of an agenda for the coming year. In this way, she indicated that

"I don't want to be prescriptive. We would rather put it the other way round - to ask the trust to produce their programmes for our perusal. If they satisfy us, it's much simpler coming from them because they are likely to own it and achieve it."

Local providers were agreeable to this approach of contract specification. In one of the providers in this area, although the CA committee chair was

concerned that audit should not get too enmeshed in contracts (for fear of looking "too much like management"), a colleague noted that "the only debate is about what's in the programme."

The contract specification proposed by purchaser A was similar to purchaser (C) and to other aspects of their 'non-prescriptive' approach. The purchaser offered provider CA committees the chance to draft the content of the contract which was then discussed and negotiated with the purchaser audit team. Thus, "the area of sensitivity is how we manage those discussions and how it is perceived" felt one purchaser manager. This mechanism was largely based on the lead officer's attitude:

"Whilst I believe passionately that if it's going to influence the quality of the service, we have to constantly improve the links between clinical audit and the contractual framework which is the thing that drives the whole beast - just throwing it together in documentation terms and funding terms doesn't satisfy that."

Her approach enabled the contract to reflect and incorporate the commitment of the CA committee in meeting those specifications. A chair of a local CA committee welcomed the chance to propose a draft to the purchaser since it would enable the provider to reassure that purchaser that CA money was being used effectively. This, in turn, would lessen the need for the purchaser to intervene in the provider's audit programme.

To conclude this section on contract formulation, the issue of the transaction costs of CA demands attention. Transaction costs refer to costs incurred before and after the market exchange between purchasers and providers. The costs include the writing of contracts, the execution of contracts and their enforcement (Appleby, 1994). The formulation and execution of CA contracts, depending on whether they are separate, appendices or integrated into main contract (see chapter 2), will incur large transaction costs proportionate to the contract price. A non-prescriptive approach, as those outlined above, to contract specification, involving CA committees as described above, would probably minimise such costs. However, subsequent contracting decisions would not be based on empirical evidence. A key element of transaction costs is the monitoring of the contract. This is explored next.

Monitoring of CA contracts:

Rumsey *et al* (1994) found that most monitoring of CA contracts was retrospective and paper-based. They found that most purchasers were not satisfied with the information they received from providers although most did attend some of the providers' audit committee meetings. This study found that, whilst a number of findings were similar to the Rumsey study, monitoring had developed to include a wider and more detailed range of mechanisms.

Firstly, it is important to stress that the nature of CA contracts is different to that of main contracts, thereby making monitoring of either difficult and certainly different. One purchaser lead officer succinctly expressed this difference and its consequences:

"We have debated that [issue] within the clinical audit committee. The view that we have arrived at is that the nature of the activity in clinical audit is very different from the nature of the activity in the mainstream contract. Therefore it is difficult to be certain that the people we field from here or that the trusts field would be comfortable in picking up that part of the contract as part of routine monitoring."

Therefore contracts managers may not be appropriate individuals to monitor the CA contract. Thus those who had formulated the contract (see above) were more likely to be involved in monitoring it.

The forms of monitoring included the paper-based exercises such as annual reports, forward plans etc. indicated by Rumsey *et al*. Other forms also included purchaser representation on provider CA committees, detailed reporting of selected audit topics, 6 monthly reviews and purchaser audit team meetings with provider CA committees.

All purchasers had decided or had been invited to be represented on provider CA committees. The extent of such representation varied. In one case study area (A), the lead officer sat on all provider CA committees as well as the MAAG which gave her an unparalleled view of the developments across the district. Her involvement in committees helped her identify the audit activities in the trust that link to other initiatives such as Research and Development.

Supplementing this representation was a meeting between the purchaser audit team and each of the CA committees 6 months into the contract period.

"At that point, we would be reviewing their annual report from the previous year and how they felt things were going this year... We have a year-end review which says 'how-was -it-for-you?' type of thing but separate from the main contract monitoring" explained the lead officer.

These in-year arrangements overcame the problem of annual reports and forward plans not coinciding with CA contracting process. A chair of a CA committee in another area was disappointed that invitations to the purchaser to attend committee meetings had not been accepted.

"We have invited for at least the last year, if not longer... someone from the [purchaser] to come on it [the committee] but no-one has ever come to a meeting... I would like them [purchaser] on that committee to hear what goes on. I'm surprised they are not considering how much money they are spending on us."

Purchaser (B) preferred an approach which distinguished between different types of audit, viz. purchaser-led audits and other audits. Both would be supplemented by traditional monitoring. Monitoring of the former would involve detailed reporting:

"I think what we said is that were going to specify 2 or 3 topics that we wanted detailed feedback on and that we wanted an annual report at the end of the year and that we would do an annual review [of providers] with... the Region."

[The Region had conducted annual reviews of provider's CA programmes and had involved purchasers in this process]. This contrasts with the other type of audit, as described by the lead officer:

"What we've tried to do in our contracts is make provision for on-going audit that we don't want to know about - we just assume that people are doing it. 50% is go-away-and-do-audit - it would be nice

to hear about it.... If it's an effective audit, then it's having an impact whether we've had the results or not."

In this example, the monitoring of the contract reflected the way in which the purchaser had addressed its responsibility for the allocation of CA funds. However, one contract manager indicated how monitoring of CA might be linked more closely to that of the main contract:

"Clinical audit did not appear in the mid-year review [of the main contract] but that's not surprising because we've only just signed the contract. Maybe next year that [clinical audit] ought to be an essential feature of the mid-year review... That hasn't become part of the mainstream this year."

The monitoring of the CA contract inevitably raises the question of the action that might ensue if evidence is revealed of the contract not being fulfilled. This paralleled on provider manager's concern of CA progress being presented to trust management boards. "Part of that overall quality reporting is audit... and you're left with the feeling of 'so what?'" This is the focus of the next section.

6.3 Incentives in clinical audit contracts

To enforce the CA contract, an incentive structure is required so that penalties (sanctions) and/or rewards encourage compliance and/or to improve performance. Rewards refer to the bonuses that may accrue to individuals, directorates or trusts as a result of favourable results demonstrated by CA. These bonuses may be financial, contractual or organisational/managerial. Penalties refer to the disadvantages that may accrue to individuals, directorates or trust as a result of the inferior audit results.

Incentives may pervert the behaviour of clinicians although they may also facilitate the achievement of purchaser's goals for audit. It is important to distinguish between the incentives applying to the CA contract and those applying to the main contract. Incentives applying to the former will have little impact if clinicians see CA as a marginal activity. However, penalties or rewards applied to the main contract may adversely affect clinicians' attitude to and participation in CA. Thus the whole issue of incentives were seen by people in this study as a difficult area to tackle but "it is undoubtedly the

direction we want to take it [audit] in", described one purchaser manager. Above all, the need to be sensitive to clinicians' fears and therefore to allow time for incentives to evolve was stressed.

In relation to both penalties and rewards, two basic stances have been adopted by purchasers in this study. The first is that incentives are blunt or inappropriate instruments for purchasers given the general aim of encouraging all clinicians to audit their own practice. The second stance is that the incentives available at the moment are poorly developed and need time to be refined. Both stances are manifest in the views of penalties and rewards.

Incentives as blunt instruments:

Rewards and/or penalties were seen by many as ineffectual in achieving what purchasers required from CA. Three positions were proposed: the impact of the incentive is unknown or counter-productive, provider (management) action should precede purchaser incentives and incentives would have negative impacts on financial and contractual relationships between purchasers and providers. These are now discussed.

Some incentives (such as financial ones) may be counter-productive especially if they are targeted at CA departments. One facilitator (case study C) expressed her fears if the purchaser imposed penalties:

"We've already try to say to [the purchaser lead officer] - 'you put a financial penalty on me, the consultants don't give a hoot.' It just gives me a nightmare because I haven't got enough money to survive the financial year or to pay my staff, so I get rid of one..."

One CA committee chair (case study C) thought that the reward for CA should be

"...your service development... [But] that wouldn't help Joe Public on the outside. If he gets leukaemia, he gets wonderful service but if he needs a hip replacement, he won't. You will have a wonderful haematology department and an appalling orthopaedic department."

In another provider (case study A), the reaction of one manager to the use of incentives was dismissive:

"Can you believe that people [clinicians] are going to be honest and rigorous in their audit if they become aware that managers, not even other clinicians, are going to get hold of results and use it against them... I hope that purchasers have got more sense than that I don't think they need to because purchasers have got other tools that they can use to evaluate the success or otherwise of a service -just as managers have."

This quote raises an interesting question as to what the purpose of purchasing CA is. If purchasers cannot use such information in the ways suggested by this manager, it would appear that CA is of limited value to purchasers. CA may then become a symbolic activity.

Provider action, rather than purchaser incentives, was the second type of response to the view that incentives were blunt instruments. Thus, audit results showing favourable or unfavourable results should, in the first instance, be the responsibility of clinicians including the CA committee. Only later would provider management be involved. These groups, rather than the purchaser, should take action as required. One CA facilitator (case study C) felt that purchaser sanctions, assuming unfavourable CA results, should be the 'last resort.'

"I think the onus should be on both the purchaser and provider to get it right... If something was that badly wrong,... I think the purchasers would be very much involved in the hands-on stage of trying to put it right. They can't be seen to be purchasing bad services either as we can't be seen to be providing them."

Although one CA committee chair recognised incentives were "unexplored territory", he felt that the focus should be on "action" not "sanctions." The first action should be for the CA committee chair (case study A) to talk to the department.

"It's much more likely that they [the department] are wallowing in a little bit of ignorance and a large slice of overwork and a lack of organisation. That is something you can help them with" he explained.

This view was supported by the purchaser lead officer:

"If it's an issue about what sanctions are available for people who are not doing it [CA], I would expect the clinical audit committees to operate those first."

She explained that discussion with CA committees had concluded that they were not ready to introduce purchaser incentives.

The third type of response related to the organisational and contractual impacts of incentives. Even the notion of a CA contract, varying from one year to another, provoked some concern as one provider clinician (case study A) indicated:

"You can't, year on year, alter the contract and have a consistent approach to audit."

Similarly, the chair of a provider's CA committee (case study C) felt that a link between CA and contracts would create undesirable incentives. For example, he judged that the withholding of CA money until a CA programme is produced was

"...not a very good threat. I think you should fund audit otherwise no audit will be undertaken at all."

A clinical adviser from one purchaser (B) recognised the tension between incentives and encouraging clinician involvement in audit.

"The only penalty directly related to the audit process would be if there was a failure to complete the audit... that would be a legitimate penalty."

However, this adviser later said that

"If in year one... it [CA contract] penalises providers for not achieving targets, then you're going to have one year's audit and then after that people are going to be cagey about it."

Incentives need time to evolve:

Common to all case studies was the second stance, that purchasers were not yet experienced enough to discriminate in this way. Opinions of purchasers and providers were divided into two views; one which stressed the need to act cautiously and let incentives evolve, the other which anticipated incentives being used eventually in contracting for CA.

Although many purchaser staff were beginning to think about the possibilities, they admitted they were not in a position to act. One purchaser manager (case study B) explained that her purchaser was

"...still some way from using that sort of information directly in purchasing."

Besides, some felt that any rush to implement a system of incentives related to CA would be inimical to its long term development. Purchasers were advised by some in this study to introduce such a system warily. One CA committee chair explained this argument:

"If you tried to do that initially [introduce incentives], the thing would have just collapsed completely... It was worth playing this long diplomatic approach in order to keep people interested and hopefully it will take over with positive enthusiasm from the bottom layer rather than having to be deposited from above."

Mostly, incentives were seen as "a very real possibility" and "at the moment, and you could say it is perhaps a bit too comfortable, that hasn't happened", according to one provider clinician (case study A). Though seen as a "comfortable" position by this instance, others felt that there might need to be some "test cases" of where incentives are introduced so as to make clinicians realise the role of CA. A purchaser lead officer (C) was careful to point out that the 'stick without the carrot' does not necessarily help clinicians to change practice, although there may be times when the purchaser needs to be assertive in addressing "outliers", clinicians' practice that do not meet agreed standards.

"One has to be careful because part of audit is about building relationships so that it is not threatening because if we just immediately take the findings into contracts - that's very unhelpful..."

That may be a tool we have to use with those clinicians who, at the moment, are not embracing audit as perhaps they should."

The second set of views regarding the evolution of incentives involved the anticipation of their use in contracting, either of the CA or the main contract. For one CA committee chair (case study C), some influence upon his clinical colleagues was welcomed.

"A certain amount of clout - without being threatening clout - has got to come into the process. 'We're all at it together chaps' hasn't actually worked because it works to the advantage of those who don't want to do anything about it."

This view was translated by a purchaser manager in this same area (C) into a call for linking CA results and funding.

"We've put money into fund the culture and it hasn't delivered anything... They've been given the opportunity and essentially they've not delivered. We are now going to say 'we are going to put the money against the results.'"

Another committee chair in this area (C) felt that the poor participation rate in CA in his trust CA was "because there is no penalty for not undertaking audit." For him, the penalties would be financial ones against the trust and passed onto the department, whilst the rewards would be "your service development." Financial incentives, like those indicated by the committee chair, were one type of reward, according to the purchaser's lead officer (C). For her, "part of your final contract funding will depend on you delivering audit." A manager in the same purchaser proposed a more conditional link between audit and funding:

"The incentive will be that if you do clinical audit properly and demonstrate a real shortfall or whatever, then they are more likely to get the resources."

However, one CA committee chair dismissed this view by saying that

"...to expose resource inadequacies is not necessarily to move the game forward... Against this dispiriting background, the small information you gather in audit in one hospital is just seen as another resourcing difficulty."

These examples show how purchasers were not necessarily thinking of moving contracts between providers due to evidence revealed through CA but rather incentives are planned which will involve purchaser decisions about the efficacy and progress of provider CA programmes.

Many of the issues concerning incentives allude to the role of CA committees and provider management as being an intermediary between clinicians and purchasers. The role of management in CA is the subject of the next chapter.

7. Managerial involvement in Clinical Audit

This chapter considers the involvement of management in the structures and processes of CA. In particular, attention is paid to provider management and the interaction with clinicians within their own unit and with purchasers. Managerial involvement in CA is increasingly seen as a critical issue since its history has been one largely of managers exclusion. But, recent policy statements, stemming from 'Working for Patients' (1989), have given managers a foot-hold. How managers develop that foot-hold and ensure that CA no longer remains an esoteric activity, whilst, at the same time, ensuring clinicians' confidence and participation will be of immense importance to the future development of CA. Developments in CA have been complicated by the changing nature of management during this period.

Four main themes are addressed:

- the purpose of managerial involvement in CA
- clinicians' concerns about managerial involvement in CA
- the organisational structures associated with managerial involvement and
- management action that may be taken within the provider

(Some issues have been addressed in other chapters and are referenced accordingly).

7.1 The purpose of managerial involvement in clinical audit

Although the ostensible aim of managerial involvement in audit was originally to enable aggregate information to be used for planning purposes, both CA and provider units have since changed. The Thomson Report (1993) (see 3.3) is probably the most lucid and recent account of the interaction between managers and CA. It identifies a number of processes for which managers now use CA. These include outcome measures, quality assurance, measures of quality (eg. patient satisfaction) and resource management. Issues such as the interpretation of CA results and selection of topics thus necessitate a more discerning approach by managers to CA.

Even since the Thomson Report, the context of CA has changed. One of the principal purposes of CA that emerged during this study in relation to provider management was the contribution that it could play to the 'mainstream business' of the trust, viz. the support of CA to the aims and commitments of the provider. CA is thus no longer advanced as an esoteric activity isolated from other processes. One CA committee chair (case study A) recognised the changing organisational position of CA:

"Because quality and audit are now part of all the contracts, we can't pretend audit is a nice cosy, confidential medical pursuit. It is integral to a lot of structures."

CA is having to survive in a wider context where it is having to demonstrate its effectiveness and contribution. One CA committee chair (case study A) likened this to stages of growth:

"It is almost as if it [CA] has had its childhood, early adolescence and it is going to have to start functioning in a broader world. I think it can."

Another purpose of managerial involvement in CA may be more conspiratorial than the first but concerns the often perceived role of managers in challenging the medical profession. One CA committee chair argued that the changing definitions of CA had not helped its introduction because many clinicians saw it as a managerial device.

"What was the objective of putting all that money into that thing called audit in the first place? There are 50% of doctors who still say the purpose of that was to provide a management tool to control us and therefore we still reject them [managers]."

Another expression of this conspiracy came from a CA committee chair.

"...it comes back to why audit was introduced in the first place and it was to take a critical look at the medical profession."

7.2 Clinicians' concerns about managerial involvement in clinical audit

Initial concerns with (medical) audit included the possibility that managers might assess the performance of the clinicians. Safeguards in Working Paper number 2 (see chapter 2) tried to assuage clinicians. Nevertheless, many clinicians' concerns remain and managers still need to tread carefully when entering the CA field. Two sets of concerns were identified in this study: the cautious approach to the evolving relationships between clinicians and managers and the emerging overlap between professional and managerial roles. Doctors expressed these concerns most strongly in this study and nurses' and therapists' concerns were not felt to the same degree, perhaps because fewer of them were involved.

The evolving relationship between clinicians and managers:

Given the potential difficulties of managers involving themselves in CA, a cautious approach was hardly a surprising finding. One provider manager (case study B) described "the debate that's been going on within the trust in the last year, about how we bring audit in." Although she felt "trauma" was too strong a word to depict this debate, there were, according to her, "some very strong views expressed." This issue was debated at the management board which involved senior clinicians and managers of the trust. Resolution involved the separation of managerial and professional responsibilities for CA. In this way, she and her colleagues hoped that

"...we are able to allay that [clinician concerns]... What I hope is that they see clinical audit working more, plus I think you have to earn respect.... [Then] those sort of anxieties do tend to subside."

The approach adopted by this provider reflected those of others in the study. For example, other managers spoke of how it was "important not to disrupt some of the basic principles of audit" whilst recognising it as a process that should involve managers.

"The line that we've taken with audit ever since the outset of this trust is that it is something where managers do need to have an interest, they need to be actively involved in the audit process and setting the audit agenda but they should respect the need for

professions to have their own boundaries within that" (provider manager, case study C).

This sort of approach helped to instill confidence in clinicians

"that they can go away and critically examine their own practices and they're not going to have some Mr. Big looking over their shoulder" (provider manager, case study B).

Management strategies helped to allay their fears that CA was "another stick" which managers have. If managers became "too closely involved too quickly", the result would be, like purchaser involvement in CA, to dissuade the participation of those clinicians who had previously been reluctant to audit their practices.

The emerging overlap between professional and managerial roles:

The second set of concerns related to the changing nature and the broad definition of 'management.' Management and clinicians have often been set up in opposition to each other whereas the differences between the two may not always necessarily be considerable. This was especially pertinent to the question of achieving appropriate changes in clinical practices. One purchaser (B) identified three interest groups or stakeholders, namely:

"...clinicians, management and the purchasers. You can play that triangle any way you want. Sometimes it may actually be the purchasers working with the clinicians... Some of our trusts are quite keen that clinical audit comes more into a managerial framework even within the trust."

Another purchaser (C) felt that the implementation of change would not expose divisions between purchasers and providers but between audit enthusiasts and audit sceptics.

"I can see some tensions building up within provider units where you've got a corporate commitment to audit... and you've got one or two switched-on clinicians who want to own it and see it work and done professionally."

Both purchasers' arguments indicate the erosion of distinct positions of managers, on the one hand and clinicians, on the other. In some clinical groups such as Nursing and Professions Allied to Medicine, senior clinicians act as 'managers' of their service. Moreover, clinical directorate structures are also empowering certain clinicians in managerial roles. A number of individuals in this study believed that CA and contracting had a role in this process of erosion. One provider manager who had a nursing background summarised the views of others:

"Successful audit takes place in a culture that does not attribute blame... That's about the management of change - whether it is done by clinicians, it doesn't really matter."

7.3 Organisational structures

The internal organisation of providers influences the ways in which managers and clinicians interact. This applies equally to CA as to other processes. Managerial involvement is examined here in terms of clinical directorates, management information and CA committees.

Clinical directorates:

One of themes that emerged strongly from this study was the developing links between CA and the clinical directorate structure. This reflected the general development of clinical directorates as a common form of internal provider structure. One CA committee chair (case study C) expressed the hope that CA would become integrated into clinical directorates and this would result from the assignment of CA department staff to those directorates. By contrast, a purchaser lead officer (A) thought that the involvement of clinical directorates managers (not just audit facilitators) was equally important to the development of provider audit:

"Also, the clinical directorates, clinical boards structures have meant that they have taken certain managers into their fold as part of the way in which they deliver services... Gradually the activity [CA] is integrating managers of its own volition."

She argued that the ability to implement change following CA was aided by directorate "business managers."

Directorate managers have already become closely associated with CA in most providers. For example, in one provider (case study B), CA was beginning to play a central role in directorates:

"The other thing is bringing audit into the business planning process. One of the things we are trying to do is to make sure that all the directorates, when they are drafting up their business plans, actually have that dimension [CA] in mind. Not that it is some tack-on but audit is just the same as any other resource. 'How can my objectives be enhanced by having audit there?'" (provider manager).

One consequence of these sort of approaches is the development of directorate audit groups, perhaps facilitated by dedicated audit staff, which is now a common approach in many providers. However, its potential had not yet been fully realised. One factor explaining this is the contribution of clinical directors as one CA committee chair (case study C) described:

"I'm not sure we have got through to the clinical directors that message [CA is important] but that won't come until audit is seen to be linked into service developments and contracts."

CA has been strengthened in some providers by the support of clinical directors and the incorporation of CA within directorate management boards. This is more than just including CA progress reports as an agenda item because this does not engage it with the action required to implement changes. One CA committee chair (case study A) reported how they were approaching it:

"We're trying to strengthen the links between our clinical boards and our audit groups so that audit is not just seen to function in a clinical vacuum... Putting it down to the clinical board strengthens that because the clinical board is going to be concerned with all sorts of things - budget, workload - now it is concerned with quality."

These changes no longer presume CA to be an esoteric activity but one that is built into the structures of the provider. For one provider manager (case study B), "part of audit being in the mainstream is that its organisational position is clear."

Management information:

Associated with a greater managerial role for CA is the question of how information, manifest through CA, should be used by 'managers.' Whilst CA may in itself provide clinicians with information about the quality of services, it also offers managers a useful basis of implementing changes. One provider manager (case study C) saw a joint agenda on the information issue:

"...right at the outset we recognised that getting effective audit meant that we needed a strong link between information and audit activities... So there was some mutual interests there" between clinicians and managers.

These interests have also encompassed the need to rationalise information collection. This applied equally to purchaser requests, according to some individuals. One provider clinician (case study A) described how various requests for information should coincide:

"There's a desperate need to ensure that you do have a cycle of events that includes the appropriate collection of clinical audit material that is the same as the trust's activity and cost-effectiveness material and is the same performance management material that the purchaser requires."

CA committees:

Discussion of the CA committee has been examined elsewhere in this report (see chapter 4) but it is worth highlighting a couple of issues in relation to managerial involvement. The committee represents perhaps the most critical point of interaction between CA and managers. Whilst some clinicians recognised the need for management input on the committee from the outset, other clinicians acknowledged that managers were not in a position to comment on professional issues identified through CA. One CA committee chair (case study C) expressed it thus:

"Professionally [the manager] has not got anything to say - [the manager] is going to have to bide to what the professionals decide."

Despite these sort of fundamental differences between clinicians and managers, many welcomed the involvement of managers on CA committees. One purchaser (C) was

"...delighted that all of our providers have management as part of their trust clinical audit committees..."

The need for this involvement has been heightened by the contracting process.

7.4 Management action

Incorporation of managers in CA processes and structures sets the context for their future involvement but the management response to CA evidence demands consideration. It can be assumed that management will want to respond or take action on the basis of CA results. The nature of their responses will thus affect the direction and scope of CA in coming years.

As with other aspects of managerial involvement in CA, the action taken by managers has, up to now, been cautious and deliberate. However, this is beginning to change with the introduction of managers to CA committees and CA to management structures (eg. clinical directorates and management boards) (see above). One CA facilitator (case study C) said that "senior management have just realised how important [CA] is." Another facilitator (case study B) illustrated how management action will now be linked to the CA results.

"That [management action] is something that we haven't done... From now on, all audits must have an action plan as to how they intend to implement those recommendations. That's something that came out of having [a manager on CA committee] because [the manager] can ensure that those action plans are followed through."

Whether the actions taken by provider managers, like those of purchasers, will compromise the participation of clinicians is, as yet, unclear. Further evidence will be needed to assess this position before a definitive statement but Pollitt's theory about the need for 'insulation' between quality assurance and cost savings as well as individual careers should be borne in mind here (see chapter 3). This will especially crucial when managers, responsible for directorate

budgets or trust executives, for example, are involved in CA committees. One CA committee chair (case study C) thought that

"...it is going to need a very strong manager to start handing out carrots and sticks."

Some of the specific actions that managers might take or have taken illustrate the issues described above. Some felt that management action should firstly involve the CA committee and managers in recommending the directorate to take appropriate action. One CA committee chair (case study C) thought that

"...perhaps you would do it [take action] departmentally and say 'look, you have got to get your act together and if you know who is not pulling the weight, sort it out.'"

The devolution of the responsibility for action was evident in another case study area (A). Here, one senior provider clinician explained that 'management' action could involve the reduction of directorate budget but did not foresee this in the immediate future:

"I would have to say that I would devolve that down to the department and say 'because you have not actually agreed to go along with this [CA]', if it seemed at all reasonable, 'I would say your budget is being cut by x pounds in the next year because of your unwillingness to do this.' I could use that to assist me in a management style but I think that is way down the track."

Another action would be to link CA to service development proposals. This was an important issue for one CA committee chair, a clinician in case study C, as CA would provide the "rationale" behind any request for additional funding. This would have the additional impact of involving directorate managers more closely in CA.

From the purchaser's perspective, these management actions can persuade them that the provider is able to take appropriate action in order to change practices internally. For some purchasers, this obviated the need to be prescriptive in purchasing CA. Provider management action may be in addition to that taken by purchasers.

7.5 Conclusion

Viewed as a whole, managerial involvement in CA is a development associated with purchasers' new responsibilities. Both have the potential to change substantially the nature and scope of CA, possibly to its detriment. Evidence from this study suggests that the cautious approaches to CA characterised by recent managerial policies will shift towards a more interventionist approach. Progress will be based upon pragmatic decisions, mediated through local 'politics.' However, certain indications have been clear about managerial involvement in the future of CA. CA will play a much more central role within providers and especially within clinical directorate structures. As a result, the distinction between clinicians and managers, as distinct entities, will dissipate. Management action will give CA a much higher profile, which may not necessarily mollify clinicians' fears about managerial involvement.

One CA committee chair (case study A) surmised that the status quo will no longer apply. CA will have to move into a wider arena:

"Now we have got to make the whole thing [CA] a lot more robust... We're giving the whole thing more structure. There is a danger that it becomes an elite activity that is somewhat detached from everything else and functions in a vacuum. We need to give it some definite reference points."

8. Clinical Audit and Primary Health Care

8.1 Introduction

Analysis of CA in relation to primary health care (PHC) was not originally part of this study's remit. The focus was on the Health Authority's responsibility for purchasing CA. Audit in PHC was seen as a distinct activity that should, for the purposes of this study, be examined separately.

However, following the pilot study and the survey of Health Authority/Commission purchasers, it became evident that the distinction between audit in hospital and community health services (HCHS) and audit in PHC was far from clear and increasingly blurred. It was, therefore, decided to interview the chairs of the Medical Audit Advisory Groups (MAAGs) covering the three respective case study areas. In fact, a fourth GP was interviewed because he was a member of the CA committee in one of the providers. Given the constraints of time and resources, it was not possible to extend the involvement to include other groups such as Practice Nurses. Hence this chapter examines PHC audit issues mainly from a GP perspective.

Policy changes and the changing nature of health care also help explain the reason for the increasingly indistinct boundary between HCHS and PHC audit.

GP fundholding accountability framework:

GP fundholding (GPFH) has been promoted as a major element in purchasing which, in combination with 'DHA' purchasers, form a balance between operational and strategic purchasing. The recent announcement of 'total fundholding' negates that division to some extent although, in the medium term, it will remain valid. That 'DHA' purchasers were given responsibility for CA funds suggests that CA may be classified as a strategic purchasing function even though GPs will want to influence that CA agenda.

In response to various concerns regarding GPFHs, an 'accountability framework' was produced by the NHS Executive in December 1994 and ratified in April 1995. This deals briefly with different aspects of accountability such as management accountability, "accountability to patients and the wider public" and also "clinical and professional accountability." In the two paragraphs it accords this issue, accountability is addressed in terms

of audit of GMS activities and audit of services the GPFH purchases. The (draft) framework stated that

"In addition fundholders are expected to ensure that clinical audit arrangements are in place for the hospital and community health services which they buy on their patients' behalf. GP fundholding practices should set out briefly in their annual practice plans their intentions for clinical audit in the coming year" (para.8.2).

In so far as GPFHs themselves will not establish CA contracts, they will need to negotiate with 'DHA' purchasers regarding each stage of the audit cycle. That is, they will need to develop, for example, a consensus on the topics to be audited, the mechanisms for contract monitoring, the development of comparative audit and the action arising CA results.

Clinical Outcomes Group report:

Another key policy document regarding CA in PHC is the Clinical Outcomes Group's (COG) report on 'clinical audit in primary health care' (July 1994) (see chapter 2). The group had three tasks:

- to explore the ways in which CA in PHC could be developed in the future
- to examine the ways of involving PHC managers in CA
- to assess the use of CA as a tool for quality improvement in PHC

In respect of this study, the second task is of most interest. The COG recognises the contribution of contracting to clarifying arrangements between parties and recommends the contracting guidance provided by EL(94)20 (see chapter 2). They call for a "consistent and equitable approach to resource allocation" and "clear lines of accountability for monies spent." The report also asserts that CA results should not be used for the monitoring of the main contract. Significantly, it also advises that "commissioners and clinicians should find ways of entering a constructive dialogue about the uses and implications of audit results." MAAGs, they propose, "should be replaced or restructured" to enable the CA and service development functions to be integrated.

This chapter examines five broad areas that shed light on the ways in which (Health Authority/Commission) purchasers are purchasing and will purchase clinical audit. These areas are: the concerns of GPs in undertaking CA, the development of 'inter-agency' audit, the role of GP fundholding in CA, the links that exist between MAAGs and Health Authority/Commission purchasers and the future direction of audit in PHC.

Many of the issues covered elsewhere in this report could equally apply to GPs and PHC. For example, many GPs share the concerns with their HCHS colleagues about managerial involvement in CA. Also, GPs could help play an important role in the stages of the audit cycle such as in the selection of topics or the design of standards or guidelines alongside 'DHA' purchasers.

8.2 GPs' concerns in undertaking clinical audit

It is hardly surprising that most of the concerns raised by GPs and others involved in this study are similar or the same as those issues troubling their colleagues in HCHS. The language and evidence cited were alike. For example, one MAAG chair summarised the views of his colleagues:

"They feel that there is a hidden agenda... There was a feeling right at the beginning [in 1991 when MAAGs were founded] that it was all going to be very led by managers, that it was going to be threatening, that they [FHSA] were going to weed out the bad apples, that resources would follow into areas that they had no control over."

He added, however, that GPs' concerns had been assuaged and that the converse had happened in that MAAG area. Another MAAG chair described the perception of the MAAG as the "policeman", engendering "an awful lot of mistrust."

Some differences between the perceptions of GPs and those of HCHS colleagues did, however, emerge. Some GPs did perceive (medical) audit to be intricately bound up with the 1990 GP contract. Indifference or antagonism to the contract had an inimical impact upon the growth of audit in general practice. Also, the association of audit with health promotion payments and annual practice reports had thwarted CA's development.

MAAGs had introduced a number of strategies to overcome this mistrust of audit. This paralleled some of the strategies adopted by CA committees in HCHS. One MAAG chair explained how their approach had mitigated their GP colleagues' fears.

"We felt under a lot of pressure to prove that the value of medical audit being professional and educational which is why we went straight for the heart and went for commonly occurring conditions in general practice and that are predominantly managed by GPs themselves."

There, the selected conditions were asthma, hypertension, diabetes and epilepsy and were applied across the MAAG area. Median standards emerged from these MAAG-wide audits. Another MAAG chair said that topics were not selected centrally which he found "disappointing... It's nice to keep it personal but none of it is comparable with other people." These fears tend to mean that "the minimalists seemed to prevail", making audit more of a formality than a culture change.

Preservation of practice and patient confidentiality was an important concern expressed in some cases and seemed more important than in HCHS examples. In order to overcome some of the fears outlined above, one MAAG secured an understanding with the FHSA to ensure audit information would not be attributable to practices or individuals. The MAAG chair said

"Our [MAAG] negotiations with the FHSA was that we would give you pooled, anonymised data but no more than that. We won't tell you who the defaulters were."

In conjunction with this 'agreement', the degree of dissemination of the anonymised audit results was based upon the practice's willingness to share the results.

"...what we got practices to do was to grade [the dissemination], when they applied for an audit bid... [Results could be] disseminated to anywhere, or could go just to the MAAG or it could go just to GP colleagues. There were 4 or 5 grades."

Despite GPs' initial concerns, "most weren't fussed about sharing it [results]", according to the MAAG chair.

8.3 Inter-agency audit

The definition of inter-agency audit is limited here to the relations between PHC (and especially GPs) and provider audit programmes (in HCHS). This type of inter-agency audit is sometimes called 'interface audit.'

Interviews with MAAG chairs and those involved with providers indicated the progress in moving two formerly separate programmes closer together. Predominantly, "there is some but nothing spectacular", according to one purchaser (B). Whilst both CA committees and MAAGs are still attempting to overcome the concerns of clinicians in their respective organisations, two other factors, disclosed in this study, help explain the lack of inter-agency audit. The first factor involves the finance available to the MAAG. One MAAG chair complained that

"...we've still got the same budget we started with - £80,000 which is peanuts in comparison with any one of the hospitals. Some of the best audits have come from primary care and it is because we haven't had this problem of what you do with the audit money."

The COG (1994) report indicates that the average allocation to each of the 98 MAAGs was "approximately £70,000" (p.19). The second factor explaining the progress to date was the lack of recognition of the need to make audit more oriented towards primary care. One MAAG chair described a local CA committee as "insular" and felt that CA committees, based upon single provider unit, perpetuated this lack of inter-agency audit. Evidence from elsewhere revealed that this 'insularity' was breaking down by GP representation, especially those involved in the MAAG, on such committees. This distance may have been partly explained by the medical bias in MAAG structures.

Other evidence was collated of the progress of inter-agency audit involving GPs and provider colleagues. One MAAG organised study days following a large-scale audit when GPs discussed the results. Local consultants were also invited. Outcomes from such days include "an agreed set of standards that we

will publish for their guidance which have been produced by their peers." This process was undertaken in another MAAG but was much less formalised. The MAAG chair outlined their approach in developing guidelines for gynaecological conditions.

"...the [purchaser] expressed interest in trying to make those [purchaser-wide] guidelines and I've written to the consultant gynaecologist at [3 hospitals] and I've had a mixed response... It looks what we are going to do is sit down with a few who are really interested in doing it, draw up some provisional guidelines, then have a meeting or circulate to other gynaecologists..."

Guidelines were the common form by which inter-agency audit was pursued. However, organisational aspects were also important. In addition to membership of provider CA committees, some GPs were involved in selection of audit department staff and CA training. Moreover, one MAAG planned to establish an office in one of the local providers to facilitate inter-agency audit.

8.4 Clinical audit and GP fundholding

GP fundholders, as purchasers of services, have a direct interest in the quality of clinical care being delivered. As they are also involved in audit of their General Medical Services (GMS) activities, they play dual roles in CA. With regard to their purchasing roles, however, their involvement in CA is indirect since they are not responsible for the allocation of CA funds. The Health Authority/Commission, as strategic purchasers, acts on their behalf.

The recent policy guidance states that total fundholding schemes will still not be responsible for the allocation of CA funds (NHS.E, 'Purchasing in Practice', Dec.'94, p.12). The 'accountability framework for GP fundholding' (ratified in April 1995) proposes that GPFHs must "ensure that clinical audit arrangements are in place for the hospital and community health services which they buy on their patients' behalf." Moreover, GPFHs' ability to use their savings for CA purposes will be relaxed but the extent of this is, as yet, unclear.

Many individuals in this study welcomed the requirement that GPFHs should address audit issues in their purchasing decisions since the quality of services was perceived in terms of

"...issues of access and their own subjective assessment of quality", according to one purchaser (A).

However, the Health Authority/Commission purchasers admitted that they needed to establish better lines of communication with their GPs, fundholders and others, in order to validate their decisions about CA. These decisions might involve topics to be audited or action taken as a result. In one area, there were indications that GPFHs were keen to see CA reports although the use made of them was unknown. For example, CA issues had not arisen in that area's joint DHA-GPFH meetings. However, a purchaser indicated how GPs and the purchaser might work together to act upon audit findings:

"We may get into very interesting discussions with the GPs about 'we're not funding the audit, what's your perception of the quality of the service?' If they say 'well, the quality of the service is pretty awful as well' then we are likely to start being much more rigorous about changing our contracting behaviour."

Progress had been made in one area where the Health Authority/Commission purchaser (C) had required GPFHs to approve the CA programme. One purchaser explained the approach:

"We've also agreed with the GP fundholders that we would require their endorsement to the audit programme because essentially we are going to collaborate on that."

In response, GPs had suggested topics for audit and indicated

"...the areas they feel they would include in the '95-96 programme and delegating it, saying, subject to us [Health Authority/Commission] picking up those issues, they are happy we take the lead in contracts."

The limited evidence in relation to GPFH and CA garnered from this study suggests that primary care's "capacity to embrace a wide clinical constituency and external quality standards" (Field, 1994) is still nascent. Progress towards closer GPFH-Health Authority collaboration was partial. Although one MAAG chair saw GP fundholding as a "red herring" because it was important to first establish the "philosophy of audit", the joint purchasing arrangements are crucial to the balance between operational and strategic purchasing, implied by recent policy changes in purchasing.

8.5 MAAG and Health Authority/Commission links

This section examines the links between the MAAGs and their respective (host) purchaser in terms of three key areas: the membership of CA committees and groups, the discussions that help form a mutual agenda and the contractual development between the two organisations.

The organisational structure of DHAs and FHSAs varied between case studies. One case study was located in the former Wessex RHA which had established Health Commissions (joint agencies covering Health Authority and Family Health Service Authority functions) in 1993. The other two were located in the former South Western RHA. Although this area had not established Commissions, one of the case studies had merged its DHA and FHSA functions to form a Commission, *de facto*. The development of a 'Commission mode' did appear to have some impact on the development of relations between the MAAG and purchaser in some respects but was also explained by other contributory factors.

Membership:

In one case study area (A), the purchaser lead officer sat on the local provider CA committees and the MAAG, offering a unique position across the district. Most clinicians, including the MAAG chair, did not mind her burgeoning role of coordination across primary and secondary care. Indeed, in this area, cross-membership of committees bound each organisation to the audit activities of the others. The integration had even reached the stage of 'loaning' audit facilitators between MAAG and provider projects for complex or large-scale projects.

By contrast, another case study had relatively poor MAAG-purchaser collaboration. Whilst the lead officer had hoped to co-opt the MAAG chair onto a strategic audit group, the level of collaboration was slight. This may be explained by the nature of general practice in the area and the organisational factors affecting the purchaser rather than necessarily a comment on the aspiration, of both sides, to work together. The MAAG chair explained that purchasers may be more concerned with the myriad of other factors affecting their organisation than with the establishment of PHC audit mechanisms.

Mutual agenda:

There was unanimous agreement on the need for setting a mutual agenda. The agenda related to the topics to be audited rather than to any action that might arise from those audits. This mutual agenda was increasingly being set in conjunction with providers, facilitated by joint committee membership, mentioned earlier. One purchaser had

"...always suggested topics... Then it's been faithfully reproduced in a MAAG newsletter... This year, the [purchaser] has looked much more closely to setting a joint agenda with their local teams. There are now contractual links between authorities and MAAGs that allows them to do that."

Another purchaser had yet to institute any such agenda but was talking about it, according to the MAAG chair:

"...we can do it by coming to terms with a five year agenda with our hospital and [the purchaser] and picking out areas and saying 'this is a quality issue'... I think there should be a common, agreed agenda in forthcoming years."

The purchaser in both cases played a crucial role in establishing this joint three-way agenda between themselves, MAAGs and provider CA committees. Building on progress to date, purchasers could facilitate change still further through their role in the contracting process. For example, one MAAG chair felt that the purchaser should emphasise 'interface audit' between primary and secondary care in the CA contract with providers. Similar mechanism could be developed with MAAGs. Re-audit could similarly be stressed. In these

ways, purchasers would take a more interventionist role in promoting a mutual agenda.

Contractual developments:

The case studies showed slightly different stages of contractual development. In one case study, the parties had wanted to establish a 'contract' to put them on a similar standing to providers. This was, according to the MAAG chair, because of uncertainty about the future of MAAGs after March 1996, the desire to "try to meet some of their purchaser requirements" and "to ear-mark those [audit] monies." A second case study approach was being adopted by the MAAG chair who had been "encouraging [the lead officer] to think of commissioning audit." At that stage, the chair could not "get their purchasers to cotton on to the fact that they could buy a similar package that we [the MAAG] could deliver." Contracts with MAAGs will increasingly become the norm as it is established with providers. This was an area identified by the COG report which would define the contribution of CA in future.

8.6 Clinical audit and PHC

As audit in HCHS providers has been moving into a wider environment so has audit in PHC. This section charts some of the moves and indicates some future directions in terms of the groups involved, the organisation of CA and the developments representing the development of a 'primary care-led NHS.'

MAAG audits have been heavily GP-oriented, corresponding to medical audit in HCHS. In consequence, other PHC groups such as community nurses have been excluded. In another area, there was, however, no nurse representation on the local MAAG team. Thus the development of multi-professional CA in PHC was patchy. Nevertheless, the study found evidence of their growing involvement such as study days involving GPs and practice nurses. Some people involved in PHC audit mentioned the need to think creatively about the future of primary-secondary care audit. For example, one suggested a joint CA committee, spanning the MAAG and providers, or even a single district-wide group with representatives of purchasers, providers and the MAAG addressing particular issues.

A primary care-led NHS should, according to one MAAG chair, be characterised by primary care-led audit. Such audits would assist in tracking patients across their whole episode of morbidity rather than discrete parts of their care in providers. Organisational boundaries thus become redundant in audit terms. This approach also assists in the development of comprehensive measures of clinical effectiveness such as patient outcomes but is predicated on effective collaboration between all parties.

Changes in primary care are shaping other areas of health policy such as CA. The future of all CA, in primary and secondary care as well as the purchasing aspects of it, are explored in the final chapter.

9. The Future of Clinical Audit: Some Conclusions

This chapter draws conclusions from the study in terms of two main areas that are emerging as critical areas of concern for the future development of CA, viz. accountability and the future purpose of CA. Conclusions and recommendations applicable to purchasers and providers follow these two issues.

9.1 Accountability

One of the recurring questions in this study was the purpose of CA. The purpose of 'improving the quality of care' provides little insight. This section explores the possible rationale of CA as an accountability device for clinical colleagues and also for external parties. Whilst recognising that definitions of accountability are problematic, Longley (1993) suggests that the essence of accountability is transparency "which needs to embrace all decision making from policy setting, through implementation to monitoring" (p.7).

The development of accountability in CA:

Audit, in health services and other settings, is now more than simply a set of technical practices but rather a set of ideas that are central to the 'administration' of organisations (Power, 1994). Accountability to external bodies (purchasers, customers, public, government *inter alia*) has become closely connected to the purposes of audit. The traditional purpose of professional development and its associated self-regulation are no longer seen as being able to satisfy the demands for accountability (Jost, 1990; Rosenthal, 1995). This applies equally to financial audit or teaching audit as it does to clinical audit.

Although CA was never specifically intended as a device to secure accountability of clinicians' activities (see WfP), the increasing involvement of provider managers and, more recently, purchasers has placed CA in a broader context which could conceivably include accountability. However, the changing environment of CA has meant that purchasers and provider managers are not necessarily concerned with the quality of clinical care *per se* but increasingly the systems established to ensure that quality is developed and maintained. As a result, the trust placed in the 'provider' by the 'purchaser' becomes relocated from the operatives to the auditors. In the NHS, these are

essentially the same except where CA facilitators play a significant role. Thus, Power (1994) does not see that increased accountability is always a consequence of audit but rather it is sometimes the reverse.

"In many fields there is a sense that the tail of audit is increasingly wagging the dog of accountability and there are doubts about whether audits really empower the agents which they are intended to serve" (p.21).

Accountability through managerial and purchaser involvement in CA?

Despite the increasing involvement of provider managers and purchasers in CA, accountability does not automatically follow. Anonymised and aggregated data passed to managers or purchasers can help but is not the only way of securing accountability.

The contribution of aggregated data (passed to managers) to accountability is limited because managers and purchasers have their own sectional interests and, whilst claiming to act of behalf of the public, often exclude the public from the decision-making process. Pollitt (1993) argues that, if the main reason for involving managers, and presumably purchasers, in CA was to secure accountability of behalf of the public, then the present arrangements are insufficient to do so. Moreover, if this was the reason, then there is little justification for withholding the anonymised, aggregated data from the public themselves or their representatives (eg. Community Health Councils). This debate has been well rehearsed in terms of 'league tables' in respect to health, education, police and other public services in this country but they have been taken much further in the USA.

Alternative accountability mechanisms have been proposed (Power (1994) and Pollitt (1993)). Power recognises that agents (clinicians) cannot easily account for their actions to principals (providers and purchasers) and so "direct accountability" and "active interaction" may help overcome such difficulties. The former is especially problematic in a public-funded health service where the clinicians account directly to users but the latter may have applicability if the purchaser works collaboratively with providers (clinicians and managers) on the one hand and GPs, users and the public on the other. In these ways, Power proposes more "modest" aims for audit that transform the external review element "from long distance, low trust, quantitative, disciplinary and

ex-post forms of verification... to local, high trust, qualitative, enabling, real time forms of dialogue with peers" (p.49). These forms might include close, on-going liaison between purchaser and providers that facilitate the implementation of change rather than create doubts among clinicians about the purchaser's 'hidden' agenda.

Pollitt (1993) sees the emergence of two forms of audit: internal and external. Internal audit is described as the medical model, based upon professional development and education. External audit is the process of reassuring the public and purchasers. Both may co-exist but they have slightly different aims which reflect the ways in which audit can no longer be seen as having a singularity of purpose. However, only external audit can fully satisfy the demands of accountability. Internal audit is thus a peer review mechanism. Pollitt suggests two factors for "full accountability" (1993, 210): an incentive structure to reward/penalise high/low quality providers and a mechanism to allow the public to influence purchasers. The former is discussed in chapter 6 and the latter by Sue Barnard in her parallel report. This division of internal and external audit is analogous to the division between accountability of the audit process and accountability of the audit outcome. The former is the preserve of clinicians and so involves a different relationship between the audit and the auditee compared with the latter. The latter contributes to accountability by enabling purchasers to act upon the results of audits. In these ways, clinicians have greater control over their 'work situation' whereas managers have greater control over the allocative decisions affecting the organisation (Dent, 1993, 266).

The notion of internal and external audits provides a framework for purchasers in managing the allocation of CA funds to providers. For example, internal audit may be pursued by clinicians through funding allocated on the understanding that the purchaser does not intervene in the selection of topics or its outcomes. Alternatively, it may refer to the provision of infrastructure funding that enables all provider clinicians to make use of the audit department facilities. However, the converse is that external audit requires certain conditions to be met such as the transfer of audit results and the understanding that action may be taken as a consequence. Likewise, funding for such specific audits may be conditional. The balance between internal and external audit will inevitably vary between areas and will need to be the subject of local

negotiation. Also, a strategic group of purchasers and providers can examine the broader, external issues whilst CA committees can be involved in internal audit.

This internal/external division limits accountability largely to external audit but preserves some part of CA for confidential peer review. Accountability can be supplemented by following Power's advice for local, high trust, qualitative, enabling and real time forms of dialogue with peers. This may be achieved through close purchaser-provider links on audit committees, audit project, training and discussion of the implementation of audit findings.

9.2 Future development of clinical audit

As 1994-1995 was the first year of purchasers' responsibility for CA, it is worth considering some future scenarios. These scenarios, shaped by health policy, concern the boundaries of CA, the future shape of purchasing and the management-clinician interface in providers.

Boundaries of CA:

Much of this study has explored the boundaries of CA in terms of what various individuals and organisations see as the legitimate function for CA now that the funds are allocated through the purchaser-provider mechanism. No single function or purpose emerged and it is likely that CA will need to satisfy multiple expectations which may result in a conflict of interests. However, it is possible to assess the limits of CA and thereby see where it fits together with other forms of (quality) assurance, accountability and change management. These include accreditation, total quality management (TQM) and value-for-money studies.

The boundaries of CA are not immutable and will be shaped by a myriad of local and national factors. The contingent nature of the development of CA was evident in this study and seemed to be strongly influenced by clinical and organisational leadership of the purchaser lead officers and the chairs of the CA committee. Their actions were obviously circumscribed, to some extent, by the development of local purchaser-provider relations and clinicians' attitude towards CA. However, their actions will need to be increasingly linked into the structure and processes of both organisations as CA moves from being an esoteric activity to one with various different aims. This may

conflict with fellow clinicians' views of CA. Such individuals will therefore need balance competing claims of CA. Their task will be largely one of ensuring insulation (Pollitt, 1993) between clinicians' desire for internal audit and managers'/purchasers' desire for external audit.

As CA develops an external element (in order to secure accountability), it will become more closely associated with accreditation and provider strategies of change management. Though not widely developed in the UK at the moment, accreditation plays a similar role to CA in reassuring external parties (purchasers and the public) of the mechanism for controlling the quality of performance in that organisation. CA and accreditation may not yet be overlapping in aim or approach but the potential exists for some confusion between the two. Providers and especially purchasers will need to consider the relative contribution of each in fulfilling their mandate as agents of the patient/public.

Provider strategies for change management will increasingly compromise the esoteric view of CA, much to the chagrin of some clinicians. Provider managers, like purchasers, thus need to become aware of the extent of the contribution that CA can play to their own strategies. The closer involvement of provider managers, such as Trust executives on CA committees, will alienate some clinicians but it should be stressed to them that provider managers can and possibly should only play an external audit role. The (limited) blurring of managerial and professional roles, as manifest in some clinical directorate structures (see below) will determine the nature of and extent of this form of external audit.

The management-clinician interface:

Clinical directorates are becoming a common approach to the internal structure of many providers and evidence from this and other studies (eg. Walby and Greenwell, 1994) have highlighted the potential importance of and the conflict associated with them. Many in this study referred to them as a crucial interface between clinicians and management which will, in the future, increasingly include CA also. Some providers are beginning to establish CA groups at directorate level. Furthermore, the management functions of budgeting and implementation at this level may compromise clinician participation in CA. Clinical directors, business managers and directorate audit groups will need to be aware of these potential conflicts.

Contracting for services at directorate level is increasingly common but this implies a closer linkage with CA which, again, may jeopardise clinicians' participation in audit unless an internal/external division is adopted. The study showed providers had not implemented contracts for CA with individual directorates although some thought they might do so in the future. The incentive structures must be carefully assessed to protect audit as an internal exercise and yet provide meaningful information. Insulation will need to be established between audit information and contracting or individual careers to safeguard the internal/external division. Furthermore, directorate-based CA involving a division between internal and external audit will pose difficulties for coordination of audit activity across the provider. Therefore, the CA committee will need to take definitive action in coordinating the potentially disparate audit activities.

The development of clinical directorates may also have an impact upon the evolution of multi-professional audit. As directorates provide an integrated approach to the delivery of care for one specialty, it is likely that multi-professional audit may be far better coordinated, perhaps with audit results being far more focused than otherwise might be the case. However, directorates arose "from a recognition that... doctors were only marginally involved in the management of hospital budgets" (Walby and Greenwell, 1994, 149). It is, therefore, likely that doctors and nurses will be much more accountable to the clinical directorate structures, possibly compromising their CA participation. However, doctors' ability (compared with nursing) to resist being 'managed' may partially hamper this development.

The future shape of purchasing:

The recent development in purchasing has been characterised by substantial changes such as the planned introduction of total fundholding, the amalgamation of DHA and FHSA functions and the shift towards primary care-led purchasing. Purchasers' involvement in CA therefore represents one more change to an already hectic agenda for purchasers. Indeed many said in this study that purchasers' lack of progress in purchasing CA was partly due to their heavy workload in other areas. CA was not always perceived as a high priority. However, CA may help purchasers in ascertaining the effectiveness of local initiatives such as the shifts from primary to secondary care. Some purchasers and providers are already using audit to assess additional service development investments.

Given that 'DHA' purchasing functions have become more strategic with the development of GP fundholding, CA appears to represent a strategic function. Responsibility for the allocation of CA funds will remain with the 'DHA' purchaser but the effects of CA will be felt across primary and secondary care. GPFHs, as purchasers, will take a much more active approach to CA and providers will need to demonstrate the effectiveness of CA to justify the non-ring-fenced expenditure.

Although over £220 million has been spent on CA between 1989 and 1994, it is unclear how far this commitment to continued expenditure will continue. Many have questioned the spending levels given the apparent benefits derived. The future level of funding from central government remains uncertain but it is likely that the allocation of CA funds will become a contested issue locally now that purchasers are responsible. This will test the robustness of local purchaser-provider links. The investment of CA funding in community health services, often characterised in the past by poor audit programmes, might appear to be contentious especially for acute sector providers but, at least in the short to medium term, development of audit infrastructure should be seen as a priority in such providers.

9.3 Conclusions

To distil some of the conclusions from this study, it is useful to make conclusions that form the basis of the recommendations that follow.

What is the purpose of CA in its changing environment?

Evidence from other studies suggests a multiplicity of aims for CA as it becomes part of an external review mechanism. However, the case studies here seemed to have more limited aims for CA, at least in the short term. Greater participation in CA, greater linkage between CA and provider structures and processes and also greater connection between CA and effectiveness studies seemed to be common purposes underlying the vague goal of 'improving the quality of care.' It was unclear how far these aims would translate into more prescriptive purchaser objectives in the longer term.

Multiple aims will probably be expected of CA and therefore, purchasers' aims are unlikely to always complement those of providers and/or clinicians. This may lead to conflict but, given the acceptance of the 40-40-10-10

breakdown as an encouragement to collaborate, this conflict may be minimised in the future. Cross-representation on CA committees and strategy groups will facilitate this. Where conflict may, however, arise, is the tension between supporting infrastructure costs as opposed to funding for specific audit projects. Split funding, recognising the value of internal and external audits, may overcome such difficulties.

Is spectrum of purchasing approaches appropriate?

Originally, a spectrum of purchasing approaches was envisaged (figure 2) but, following the study, it is not possible to fully sustain this notion. Purchaser approaches are more subtle. Not only may they pursue varying approaches between different stages of the audit cycle but they may also adopt different strategies according to the development of the audit function in their respective providers.

However, it is possible to draw some conclusions from the spectrum in that all purchasers were wary of being too directive too quickly, allowing the contract culture in CA to develop. Purchasers recognised the limited benefits that a truly directive approach could bring and most did indicate that, in general, a collaborative, developmental and long term relationship was being sought. The local purchaser-provider context was thus a crucial factor in the approach to purchasing CA in the South and West. The first year of CA contracting was thus atypical.

How can clinicians be assuaged of the perceived impacts of purchasing CA?

The two previous conclusions indicate purchasers had been making progress in CA in a deliberately slow or steady fashion. Likewise, providers have been integrating CA into mainstream provider business at a similar pace. Both approaches have been designed to minimise the inimical impacts perceived by many clinicians. Three (inter-related) strategies emerged from this study, designed to ensure clinician cooperation in CA but also provide purchasers and managers with meaningful information.

The first strategy, "insulation", was designed to separate CA from cost savings or contracting, on the one hand, and CA from individual careers, on the other. An individual's dual roles in budgets or management and CA was seen to be insufficient separation, without other safeguards. Likewise, anonymised,

aggregated data allayed clinicians' fears of being penalised or judged. However, the level at which some information may be aggregated is the clinical directorate which partly contradicts the insulation of CA from managerial action. Directorates are also increasingly the location for contracting.

The second strategy was an incentive structure involving rewards and penalties. Most purchasers had yet to introduce anything more than rudimentary incentives but were considering them. However, a tension emerged between those who saw that incentives were blunt, ineffective instruments and those who saw that incentives need time to evolve. It appeared unlikely that incentives would apply to anything other than the CA contract, at least in the short term.

The third strategy was the division between internal and external audit. This existed to a limited extent before purchasers' were allocated additional responsibility but it is now being formalised as an explicit strategy. It is based on an understanding that CA has different aims, different stakeholders and therefore requires different approaches. Such a strategy can help resolve a number of dilemmas in CA such as the balance between purchasers' and clinicians' agenda, infrastructure costs and costed audits, external accountability and clinician peer review. Although external audit appears to offer a more directive approach for purchasers, sensitivity and imagination should be given to promoting long term approaches to CA involving, for example, re-audit and audit of routine issues.

These three strategies are neatly summed up by Berwick:

"The outsider can judge care but only the insider can improve it. Purchasers have a responsibility as the outsiders to engage the attention of the insiders and the insiders have a responsibility to respond."

(quoted in 'Purchasing in practice'(NHS Executive), issue 1, December 1994, p.11).

9.4 Recommendations

Purchasers:

- 1 to re-assess the aims and objectives of contracting for CA given the experience of the 1994-95 contract. This re-assessment should consider the aims of different types of audit and the level of involvement by purchaser staff.
- 2 to ensure the effectiveness of the CA function in the purchaser. This can be achieved by integration of CA into the mainstream business of the purchaser, facilitated by means of a multi-professional purchaser audit team. It can also be achieved by identifying and meeting the training needs of purchaser staff involved in CA.
- 3 to establish a systematic approach to the selection of topics to be included within the CA contract.
- 4 to confirm the form of CA contract (separate, appendix or integrated) that is most appropriate to the development of a trust's audit programme. This would also involve analysis of the contract's associated transaction costs.
- 5 to incorporate an element of re-audit and comparative audit between providers (where appropriate) into CA plans and subsequently CA contracts.
- 6 to secure cross-representation on CA committees and groups. This could also involve the formation of a 'district-wide' strategy audit group with members from the Health Commission, MAAG and provider CA committees.
- 7 to secure the responsibility for developing inter-agency audit, especially audit between primary and secondary care. (This could be achieved by the strategy group (see recommendation 6). Responsibility should involve an extension of audit to primary health care groups such as community nurses who had previously not undertaken audit to the same extent as GPs.

- 8 to promote multi-professional audit by devoting greater importance to it in the CA contract.
- 9 to consult and agree with GP fundholders and non-fundholders the basis of the purchasing strategy for CA. This would include agreement about the topics to be audited, the monitoring of the CA contract and action to be taken following audit results.
- 10 to agree and implement appropriate strategies for securing internal and external audit including adequate "insulation" for clinicians. This should address, *inter alia*, issues of funding, selection of topics, the different levels and contents of contract monitoring and the use of CA results.
- 11 to act upon an assessment of the benefits and drawbacks of the incentives that the CA contract has introduced, *de jure* or *de facto*.
- 12 to decide upon the most appropriate form of funding, so as to achieve a balance between funding infrastructure costs or provider CA programmes and attaching funding to specific audits. This should involve assessment of the conditions under which additional CA funding may be allocated.

Providers:

- 13 to ensure that CA is incorporated into the mainstream business of the provider. This can be achieved through the suitable arrangements for the management responsibility of the audit department and the appropriate representation on the CA committee.
- 14 to provide "insulation" between CA from contracting and individual careers. This should address, *inter alia*, issues of audit department support, clinician ownership of audit, topic selection and use of results. This insulation should protect internal audit whilst also meeting their requirements for external (purchaser) audit.

- 15 to ensure appropriate mechanisms for undertaking multi-professional audit. This should include dedicated time for audit among groups previously unable to access audit assistance as well as facilitating audit among clinical teams.
- 16 to assess the contribution of CA in service development.
- 17 to develop collaborative audit arrangements with primary health care. This can be achieved through cross-representation of audit committees and groups and can be facilitated through participation in a strategic audit group (see recommendation 6).

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