

Clinical Audit Today

Volume 2, Issue 3.
September 2009

Editorial: 20 years on – is the clinical audit glass half full or half empty?

Stephen Ashmore

Director,

Clinical Audit Support Centre

Editor, Clinical Audit Today

It appears to have slipped the attention of many, but 2009 marks the 20th anniversary of clinical audit. *Working for Patients* White Paper was the document that formally outlined plans for “medical” audit and the last twenty years have seen audit become increasingly embedded within healthcare systems. With Margaret Thatcher as Prime Minister, Jason and Kylie ruling the pop charts and average house prices of £36,000... 1989 seems a distant memory... but as audit enters its third decade is there reason to be pessimistic or optimistic?

Let's start looking from a “glass half-full perspective”. Although there is currently more clinical audit being carried out than ever before it is still difficult to find examples and case studies of great audits that have dramatically improved patient care. I was recently asked, along with Robin Burgess and Martin Ferris, to review one-hundred audit abstracts that had been submitted for a national event and we spent most of the day shaking our heads! Many projects weren't audit and most failed to show any direct improvement in patient care. Enough said.

I also keep hearing from others about clinicians who are now embracing audit freely... thus far I'm not convinced of this. Of course, more clinicians are starting to get involved in audit but from my perspective this is largely due to contractual, revalidation, commissioning pressures. 95% of junior doctors I teach on a regular-basis still see audit as a rather pointless activity and this is borne out by a group I taught lately who suggested that the “real” clinical audit cycle for them should read “told by consultant what to audit > contact audit team (if it exists) > complete 6 page registration form > encounter problems getting patient records > eventually complete manual data collection > data placed in queue to be analysed > time to change jobs”.

Add into the mix that most clinical audit professionals in the UK don't possess a qualification for the profession that they work in (which preaches best practice to clinicians who have all spent a considerable part of

their life studying!) and the fact that we currently can't decide what the appropriate definition for clinical audit is in 2009 and you can see why there is reason to doubt if audit will ever achieve its true potential...

And yet... despite its obvious failings, there is reason to believe that clinical audit is starting to get its act together. The dark days of 2006 when the CMO stated that “audit is falling short of its potential” appear to be behind us and momentum is being gained...

NCAAG are now well established and aside from their latest attempt to re-define clinical audit they are making progress. HQIP are also starting to produce a useful range of resources for the audit community and it is great to see that over 400 NHS staff joined the National Clinical Audit Forum within the first 6 weeks of it being launched. NCAF has the potential to truly reinvigorate the audit profession by enabling traditionally isolated audit staff to communicate with each other and share ideas, resources and experiences.

I am also starting to meet senior managers, particularly commissioners, who actually want to know more about audit and who are keen to find out how audit can help assure the quality of local service provision. Revalidation and quality accounts too, are likely to have a positive impact on audit and it is expected that few clinicians or Trusts will be able to pass off incomplete audits in the future...

The *Health Service Journal* even devoted a whole page to a national audit project recently and I have started to regularly notice salaries for vacant audit posts between £30-50K and this is likely to ensure talented people join our profession and experienced auditors don't leave for better-paid alternatives.

So twenty years since *Working for Patients* and there are reasons to be both pessimistic and optimistic. The last three years have definitely seen improvements, but there must be concerns with regard to how audit will be affected by the imminent public sector cutbacks. If audit can pass through the imminent financial turmoil ahead then there is reason to believe the next 20 years could be more memorable than the first 20.

In this issue

- 1 Editorial: 20 years on – is the clinical audit glass half full or half empty?
by Stephen Ashmore
- 2 HQIP Update by Robin Burgess
Clinical Audit Support Centre Update
by Tracy Ruthven
- 3 National Clinical Audit Advisory Group – one year on by Martin Ferris
- 4 Interview with Ben Bridgewater
- 5 Clinical governance in medical education by Eleanore Lyons, Fiona MacPherson and Catherine Johnson
- 6 It's all about Quality by George Absi
- 7 Bradshaw, Whitaker's or what? by Grumpy Old Auditor
- 8 Signposting

Clinical Audit Today is published by the Clinical Audit Support Centre Limited. All issues are freely available in electronic format via www.clinicalauditsupport.com
© Clinical Audit Support Centre Limited

Apart from any fair dealing for purposes of research or private study, or criticism or review, as permitted under the UK copyright, Designs and Patents Act, 1988, no part of this publication may be reproduced, stored, transmitted, in any form or by any means, without the prior permission in writing of the publishers.

Clinical Audit Today

Volume 2, Issue 3.
September 2009

National Updates



HQIP
Healthcare Quality
Improvement Partnership

HQIP update

By Robin Burgess,
HQIP Chief Executive

Hopefully most of you have had a chance to meet us and share your ideas for the future of clinical audit at one of the many events we have either organised or attended throughout the country over the last year.

We have taken these views on board and, since our inception in 2008, we have developed: our website, a source of reference for anyone involved in clinical audit and quality improvement; the local clinical audit conference held in April which was attended by nearly 400 local clinical audit staff from across the country, and which had very positive reviews; the clinical audit awards, which attracted several examples of extremely good practice; the launch of the National Clinical Audit Forum, a diverse and multi-layered online site to share views, gain insights and develop audit practice; and the procurement of various local clinical audit templates and tools which will be live on our website soon.

In addition to the above, one of our first tasks in our role in reinvigorating clinical audit has been to secure agreement on what constitutes markers or criteria for quality in audit. Based on extensive consultation, we have drafted a statement of what is best practice in clinical audit. This will be published at the end of September.

Earlier this year, we also finalised our three year strategic plan, available on our website, which not only puts forward the ideas we have to reinvigorate clinical audit but also draws on those you have given us. Key activities over the coming year will be:

- managing and improving the national clinical audit programme
- improving clinical audit expertise through training and resources
- building clinical audit into commissioning, regulation and validation processes
- helping clinical audit obtain professional status
- helping shape and form policy around clinical audit.

To reflect this, we are, in conjunction with the National Clinical Audit Advisory Group, commissioning six new national clinical audits in the National Clinical Audit and Patient Outcomes Programme (NCAPOP). In assessing and choosing the topics, a range of factors was taken into account - including clinical/health and social policy importance and evidence of significant variation in quality of care. We have also commissioned six new multi-site audits.

Work is well underway on our education and training strategy and we will be progressing to the next stage soon. So far, we have scoped education needs and competences for people working in audit and the next phase will see a detailed specification for courses (as CPD for clinicians or as entry level/basic/advanced courses for those who are audit specialists), with standards. Prospective course providers will then be invited to submit expressions of interest detailing how they will meet the standards.

Finally, working with the National Audit and Governance Group (NAGG), we continue to strengthen or establish local clinical audit networks across England with a dedicated development fund which aims to support the network's running costs, especially in the delivery of clinical audit events.

For more information, please visit www.hqip.org.uk



Clinical Audit Support Centre update

By Tracy Ruthven,
CASC Director

Summer 2009 has been an exceptionally busy time for the Clinical Audit Support Centre (CASC) and we are pleased to announce the launch of two new accredited courses. We are building on our collaborative work with the National Patient Safety Agency (NPSA) to offer a one-day Root Cause Analysis Masterclass from Autumn 2009. In addition, we have worked closely with professional trainer and author Andrew Cope to develop a High Impact Leadership Course for Clinical Auditors that will begin early in 2010. This course is a six-day residential programme featuring modules on the art of being brilliant, transformational leadership, high performance teams, the massive goal principle, customer service excellence and leading change. Students who successfully complete the course gain the Institute of Leadership and Management Introductory Certificate in Leadership.

Our annual national conference takes place in Leicester on 16th September and includes expert speakers such as Professor Mike Pringle, Roisin Boland, Dr Bruce Warner and Robin Burgess. We also have Dr Tim Brabants (Gold Medallist from the 2008 Beijing Games) as the keynote speaker and we will feedback details and outputs from the event in the November journal.

Our work on Significant Event Audit has led to further collaborations with the NPSA and we are in the process of developing materials that will enable PCT's to utilise our pioneering work looking at the quality of SEA reports submitted by GP practices. In addition, we have also completed work for the Royal College of General Practitioners developing online SEA teaching resources for practice staff.

As ever we are always looking to embrace new technologies and we have just set up a Twitter account that we intend to use to keep people up-to-date with our work and the latest news from the world of clinical audit. To locate us on Twitter search for "cascleicester".

We also intend to hold our first live online webinar before the end of 2010 (watch this space) and we are in the process of putting the final touches to our ten minute enhanced podcast looking at how to undertake a successful clinical audit. Using more traditional technology, we have also launched our fortnightly jobs bulletin that features all the latest clinical audit jobs. This is published every second Tuesday and is freely available online.

We are also pleased to report positive progress on the *Principles for Best Practice in Clinical Audit* book. We have had a number of difficulties finalising this, not least because of the ever changing clinical audit landscape. However we are pleased to announce that we are now collaborating with a number of partners to take this work forward (including HQIP) and we hope to complete the new version by the end of the year.

It also gives us great pleasure to announce that our team has expanded from two to three – with the arrival of Sharon Nijjar. Sharon has previous NHS experience and is our new Project Manager.

Finally, we are exhibiting at a number of events over the next six months, so please look out for us at: **the ISQua conference in Dublin from 11-14th October, Risk and Patient Safety in London from 24-25th November and Clinical Audit 2010 in London from 9-10th February 2010.**

National Clinical Audit Advisory Group – One year on *By Martin Ferris, NCAAG Member*

It seems quite a while ago but NCAAG came into existence on 1st April 2008.

NCAAG's responsibilities were determined at the outset to be:

- To drive the reinvigoration of clinical audit, both nationally and locally, yielding new publicly available information to support improvements to clinical practice and service delivery
- To be the steering group for the expanded National Clinical Audit and Patient Outcomes Programme (NCAPOP), providing advice and guidance on the overall programme of work, and in particular to consider proposals for new audits or for discontinuing existing audits
- To advise on clinical audit issues as requested by the Department of Health

The membership of NCAAG reflects a wide range of backgrounds and with varied experience of clinical audit at both national and local level. I was rather surprised, however, to find I was the only clinical auditor on the group!

Throughout the first year, NCAAG members have met with a large number of organisations that are involved with creation of NCAs outside of NCAPOP, bodies that use clinical audit to assess quality of care and those with an educational remit. This activity should lead to an alignment of goals and priorities.

The main area of work during this time has been regarding national clinical audits (NCAs). As current ones funded by DH were developed and approved at different times, by different bodies and with different criteria they are – well - different! Not all comply with the most robust criteria now in place. Separate sub-groups of NCAAG have been for considering new audits and for assessing renewals. Consistent standards are now applied to both new and continued NCAs. NCAAG has met with several of the “independent” NCAs (those not funded by NCAPOP) to discuss emerging national policies such as the criteria for good quality national audits.

A call for topics for new NCAs in 2008 resulted in 59 expressions of interest from which the following were selected, subject to final agreements:

- Chronic Pain
- Childhood Epilepsy
- Inflammatory Bowel Disease
- Heavy Menstrual Bleeding
- Treatment Resistant Schizophrenia
- Hip Fracture

One of the main problems facing NCAPOP projects is that funding for them is limited. Some time has been spent considering the possibilities of support from sources other than DH. In future it is probable that 100% funding from DH will be for a fixed term after which projects will need to obtain some support from elsewhere.

Operational support for NCAAG is provided by HQIP who have the responsibility for managing NCAPOP contracts and reinvigorating Clinical Audit. NCAAG assures the strategic direction, procedures and governance for the work that HQIP is contracted to do under its arrangements with DH.

NCAAG will be addressing the following in 2009-2010:

- Improving the quality of clinical audit:
 - Create portfolios of good quality national and local audits
 - Providing an advisory service for NCAs
 - Education and training for clinicians and CA staff
 - Support for “independent” NCAs
- Clarifying the commissioning of NCAs
 - Annual cycle for commissioning new audits to be introduced
 - Enhancing transparency of decision making for new topics based on:
 - Health and social importance
 - Evidence of need
 - Criteria of good quality
 - Supports broader DH/NHS policy objectives
- Extending the scope of NCAs
 - More in primary care
 - The challenge of audit with social care
 - Greater involvement of patients, including, where feasible the inclusion of PROMs
 - Addressing budgetary constraints
- Creating widespread participation and involvement, particularly through the National Clinical Audit Forum

The year ahead promises to be very busy!!!

To access NCAAG 2008-9 Annual Report visit their website via
www.dh.gov.uk/ab/NCAAG/index.htm

Clinical Audit Today

Volume 2, Issue 3.
September 2009

The Clinical Audit Interview with...

Ben Bridgewater
*Chair of the Society for
Cardiothoracic Surgery in
Great Britain and Ireland
database committee*



Ben Bridgewater isn't your average clinician. Not only is he an exceptional Cardiac Surgeon (search for him on google and you'll be directed to the CQC page that informs you of his high operating success rate), he also has a strong interest in clinical audit and is currently Chair of the Society for Cardiothoracic Surgery in Great Britain and Ireland (SCTS) database committee. Ben can also lay claim to being one of the few people involved in clinical audit ever to have his work featured in the Health Service Journal – quite an achievement! But then again the recent report published from the SCTS is being hailed as a world first in clinical audit leading Professor Bruce Keogh, the NHS Medical Director to describe it as “the finest and most detailed complete national audit report for a major specialty anywhere in the world”.

The report, published by Dendrite Clinical Systems, details over 400,000 patients records and features detailed and wide-reaching information regarding: coronary artery bypass surgery, aortic valve surgery, mitral valve surgery and other cardiac operations. Data has been heavily scrutinised and the report examines the methodological issues around predicting operative risk and adjusting for case mix, both of which are essential if comparisons are to be made about differing outcomes between hospitals and surgeons.

As well as reporting mortality outcomes, the publication highlights: the evolution of surgical techniques; the factors influencing surgical outcomes; five year-survival; post-op stroke rate/renal failure and re-explorations for bleeding. The report is 512 pages in length and provides full details of the findings from the audit.

After reading the aforementioned HSJ article and finding out more about the SCTS database via various online sources, I contacted Ben and he kindly agreed to take part in a brief telephone interview for the journal.

What first struck me about him is that unlike most clinicians I encounter, Ben has a very positive attitude towards clinical audit and yet sees his interest and involvement in it as nothing unusual. He did explain that cardiac surgeons have been taking part in audit since 1977 and thus a positive culture of participation in audit has developed but, even so, one cannot fail to be impressed that all cardiac surgeons routinely submit national level audit data.

Given that so many national audits have a rather mixed reputation, I asked Ben why he felt the SCTS database has proved to be such a success. He explained clearly that the audit is well designed and hospitals can submit audit data quickly and easily using a range of methods. Data is collated and analysed centrally and this enables participants to gain rapid feedback benchmarking their performance with others. Crucially, Ben made the point that the audit is “led and owned by clinicians for clinicians” and it is interesting to note that other than enlisting the support of IT experts few others including clinical audit staff are involved. Ben also described the work as “extremely cost effective” with funding for the database received via the NCAPOP budget. Certainly from my perspective it is clear that the SCTS has developed economies of scales that would be the envy of local clinical audit teams.

What is also clear about the SCTS is that participating clinicians believe in the audit methodology employed and have faith in the results generated from submitting their data. Ben agreed with me that small snapshot audits have their place for identifying weaknesses and undertaking quick PDSA projects.

However, he was equally clear that for national audits of this magnitude which effectively performance manage professionals, data must be robust, statistically valid and credible.

What also impressed me from talking to Ben is that although the work has been universally praised, plans are already being made to develop the database and make further improvements. He noted that the challenges ahead include the “faster production of reports and smarter feedback of results to clinicians”. Ben also suggested that the database could be used to examine data to assess interventions especially where there is a high risk of complications.

The final part of our conversation focused on patient access to clinical audit results and Ben informed me that in many cases patients can access cardiac surgeons audit data by entering their name into google and then in most cases being re-directed to the Care Quality Commission website. Such direct access to clinical audit data is virtually unparalleled but as Ben pointed out patients now routinely use the internet to find out more about the care that they receive. Given that few clinical audit departments currently make their annual reports available to patients online, it is interesting to see that the SCTS adopt such an accessible and transparent approach. Food for thought for many Trusts who continue to keep their audit projects and results out of the public domain.

Overall, you can't help but be impressed by the SCTS database and the work that Ben is overseeing. National audit has come in for its fair share of criticism recently, but this project demonstrates how effective national clinical audit can be. It is a model that others should learn from and try to replicate.

For those of you interested in reading the full report you can buy your copy of **“Demonstrating Quality: The Sixth National Cardiac Surgical Database Report” (ISBN 1-903968-23-2) at <http://bluebook.e-dendrite.com>**

Clinical Governance in Medical Education

By Eleanore Lyons, Fiona MacPherson and Catherine Johnson

Background

The importance of clinical governance within medical practice has been recognised by several organisations^{1,2,3}. At Nottingham University, final year medical students undertake a clinical governance project as part of their GP attachment, with the majority of these projects being clinical audits. We surveyed both students and GPs to assess the usefulness and relevance of these clinical audits, and considered ways to improve satisfaction with the project.

Context

Several organisations have recognised the value of clinical governance within medical practice. One definition of clinical governance is "a system... for continually improving the quality of... services and safeguarding high standards of care..."⁴. Clinical audit is an integral component of clinical governance⁵. The GMC insists that clinical audit is essential to the provision of good care¹ and advises doctors to partake in regular and systematic audit².

However, the performance of clinical audit in itself is not sufficient; the results of audit need to be shared amongst professionals so that lessons can be learned across the board and not merely by those who have conducted the audit. In 2006, the CMO for the DH recommended that local and national clinical audit programmes should be further developed to yield publicly available information.⁶

Clinical audit is now a compulsory part of the Foundation Programme for junior doctors⁷. In order to maximise the usefulness of these audits and minimise the time impact of this requirement it seems sensible to equip medical undergraduates with skills for clinical audit.

At Nottingham University, every final year medical student undertakes a clinical governance project during their GP attachment, with the majority of these projects being clinical audits. We believe that this is an excellent opportunity for students to gain experience of audit and other aspects of clinical governance.



The University of
Nottingham

Aims

The aims of this article are to assess whether:

- Medical students find the clinical governance project useful;
- GPs find the projects relevant and useful for their practice;
- GPs feel that it would be useful to see the results of projects carried out at other practices;

And to:

- Consider ways of increasing student and GP satisfaction with the project.

Criteria

- Medical students should find the clinical governance project useful.
- Medical students should feel that they learn about clinical governance from the project.
- GPs should feel that medical students learn about clinical governance from the project.
- GPs should feel their practice benefits from the project.

Methodology

After completion of the projects, GP tutors and their final year students at Nottingham University were asked to respond to an email survey, as described above.

Results

Student survey

Of 25 respondents to the student survey:

- 64.0% (N=16) agreed/strongly agreed that the clinical governance project was a useful part of the course;
- 84.0% (N=21) agreed/strongly agreed that the project had improved their understanding of the audit process;
- 76.0% (N=19) agreed/strongly agreed that the prospect of publication would have increased their motivation for the clinical governance project.

GP survey

Of 17 respondents to the GP survey:

- 94.1% (N=16) agreed/strongly agreed that their practice benefited from the clinical governance project;
- 94.1% (N=16) agreed/strongly agreed that medical students learn from the project;
- 41.2% (N=7) agreed/strongly agreed that they would be interested in seeing the results of projects done at other practices.

Conclusions

Our findings show that the majority of medical students surveyed find the clinical governance project useful and agreed that the project improved their understanding of the audit process. The majority of GPs surveyed agree that the results of the projects benefit their practice and 41.2% confirmed that they would be interested in accessing the results of projects conducted at other GP practices.

Recommendations

The GMC considers audit to be an important part of Good Medical Practice, and the DH recognises the value of making information publicly available so lessons can be shared. However, not all UK medical schools currently have a clinical governance project as part of their undergraduate curriculum.

As a result of our findings we feel emboldened to make the following recommendations. Audit should be part of the curriculum for the undergraduate medical degree at every university.

In addition a central database should be compiled of clinical governance projects performed by medical students so that GPs and medical students can readily access work done. This would facilitate completion of the audit cycle, enabling pooling of similar data between practices and re-auditing of previous data. An added bonus may well be improved publication opportunities for medical students.⁸

References

1. General Medical Council guidelines. Confidentiality: Protecting and Providing Information. (2004) <http://www.gmc-uk.org/guidance/current/library/confidentiality.asp>
2. General Medical Council. Good Medical Practice (2006) http://www.gmc-uk.org/guidance/good_medical_practice/GMC_GMP.pdf
3. Secretary of State for Health Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century London: HMSO (2007)
4. Scally G and Donaldson LJ Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ* (1998) 317: 61-65.
5. Starey, N. What is Clinical Governance? (2003) www.evidence-based-medicine.co.uk
6. Chief Medical Officer. Good Doctors, Safer Patients. London: Department of Health (2006)
7. The Foundation Programme Curriculum (2007) <http://www.foundationprogramme.nhs.uk/pages/foundation-doctors/training-and-assessment>
8. Banarsee A, How to publish an audit. *BMJ Careers* 2007. <http://careers.bmj.com/careers/advice/view-article.html?id=2152>

Clinical Audit Today

Volume 2, Issue 3.
September 2009

It's all about quality!

By George Absi,
Clinical Audit Manager,
Hertfordshire Community
Health Services



Summary:

- Clinical Audit is being reinvigorated locally, regionally and nationally
- With a growth in quality initiatives, this is an ideal opportunity for the Clinical Audit Department(s) to show how they "make a difference"
- It is our duty, as clinical audit professionals, to help maintain the high standards of our work and support healthcare professionals develop and undertake quality clinical audits that improve patient care
- Useful tips listed include planning, sample sizing and presenting findings.

It is an exciting time to be associated with clinical audit. The Healthcare Quality Improvement Partnership (HQIP), National Clinical Audit Advisory Group (NCAAG), National Audit Governance Group (NAGG) and the Clinical Audit Support Centre (CASC) are helping reinvigorate clinical audit locally, regionally and nationally. In-addition to this, Lord Darzi's report puts quality back at the heart of everything we do! This will lead to a growth in quality initiatives being undertaken. As a Clinical Audit professional, I feel that this is an ideal opportunity to show how we as Clinical Audit departments/teams make a difference, by supporting clinicians and healthcare professionals undertaking quality clinical audits that improve patient care, patient outcomes and service provision. Remember also that the commissioners are getting ever more demanding in their search for quality services that improve the health of the local population. All being said, I feel that it is our duty, as clinical audit professionals, to maintain the high standards of our work throughout these busy periods. For this reason I have pencilled down a few useful tips that I have picked up over the years.

Planning with the use of Gantt charts

Planning is an essential part of any project. It is necessary to set out the steps that must be taken to achieve the project's objectives.

One of the key stages in planning a project is to set out the tasks and activities and decide how long each one will take to complete. A Gantt chart is quick and easy to design and shows the key stages of a project and the duration of each as a bar chart. The timescales run across the top and the tasks are listed on the left-hand side. In clinical audit, they can be used for planning individual stages or planning the yearly clinical audit programme. In the latter this may help manage your/the department's capacity. The example below shows a mock Record Keeping audit which has been planned over a six month period. The charts are flexible, I have used months but it could be made more specific e.g. using weeks.

Stages	Months					
	Apr	May	Jun	July	Aug	Sep
Planning/ Piloting						
Data collection						
Data analysis						
Feeding back						
Action planning						

Sampling with confidence

It is rare that we can gather information from an entire population/patient group. In statistics, a confidence interval is an interval estimate of a population. A confidence interval is always defined as a particular confidence level (usually 95%). It is based on three elements including value of a statistic, the standard of error and the desired width of the confidence interval. The table below shows recommended sample sizes.

Number of patients	Sample size (95%)+/-5	Percentage sampled
200	132	66%
400	196	49%
500	217	43.4%
1000	278	27.8%

Further calculators are available from Google. The confidence level is the probability value associated with a confidence interval. In this case we have set it at +/-5%. If we used the 95%+/- 5% sampling and the results from an audit specified that 90% of patient records were marked in black ink then we could conclude, that we are 95% confident that 90% (+/-5%) of our patient records are marked in black ink.

Presenting findings using Trend Analysis graphs

Presenting the data and the results of the audit to clinicians, management and stakeholders in a clear, easy to understand, usable format is essential. This will aid in using the data to make recommendations and in the construction of the action plan. Trend analysis refers to the concept of collating information and trying to spot patterns or trends within it. I have used them when undertaking large clinical audits across a wide range of services e.g. the Record Keeping audit. We in Hertfordshire Community Health Services have 12 Specialist Children Services. It was agreed, by the Lead of the audit, that the best way to present the data was in trend analysis graphs. The analysis highlighted areas of good practice across all services and areas for improvement. In-addition to this, it also saved time as only one action plan was developed. The example below shows mock sites and standards.

STNDS	site 1	site 2	site 3	site 4
1	50%	60%	100%	100%
2	30%	90%	100%	10%
3	0%	0%	100%	100%

* Key at the bottom of the article

In summary, clinical audit is only as good as the quality of the clinical audits undertaken at local level. We as audit professionals should be willing to share our experiences and lessons learnt to continuously improve and maintain the high standards of our work. Remember, quality should be at the heart of everything we do!

Key - The traffic light system in this example:
*70-100% - Compliant
50-69% - Partially compliant
0-49% - Not complaint

Bradshaw, Whitaker's or what?

By John Grant-Casey,
Project Manager, NHS Blood and
Transplant aka
"Grumpy Old Auditor"



Anyone who has ever read any of the Sherlock Holmes stories written by Sir Arthur Conan-Doyle (which, interestingly although his most successful work was the one he least wanted recognition for – he wanted his works on history and spiritualism to be more widely read) will be aware that Holmes and the good Dr. Watson were frequently rushing off by train to solve some ineffable mystery – “The Strange Case of the Missing Krispy Kreme Donut”, and “The Politician’s Expenses” being two of the less well known examples.

In ‘The Valley of Fear’, published in 1915, Holmes is sent an encrypted letter which he has to decipher. This was, of course, in the days of the Data Protection Act 1914, originally passed to prevent it becoming common knowledge that the Titanic had sunk. It was very difficult to password protect a handwritten letter so people took to writing incomprehensible sentences to avoid the true meaning being revealed. Funny how the trend continues today with many audit reports! Strange old world! Anyway, for reasons I am not going to tell you – what do you think this is: a literary review? – Holmes decides that the coded letter must be based upon a common document that the writer knew Holmes would have, and the intrepid duo first turn their attention to Bradshaw. George Bradshaw (1801-1853) produced the world’s first compilation of railway timetables. Who’s that snoring? The Baker Street Duo found that even when consulting Bradshaw they could not make sense of the text they had been sent, so they turned instead to Whitaker’s almanack. First published in 1868 (and still available today) this was more than a railway timetable because it was a document that contained written text, lists and tables. After many hours of patient deliberation, they were able to deduce the true meaning of the missive they have been sent.

Now look, I don’t want to go on about this, but over the years I have seen audit reports that even Sherlock Holmes, his brother Mycroft, Inspector Morse, Frost, Torchwood and Dr. Who with his ability to read 5 million languages could ever satisfactorily decipher. Because the auditors who write this stuff lay out the results beautifully, as befits a railway timetable or almanack. But in these reports is not one jot of interpretation or discussion. It may be that because I have been doing this a long time that I have come to the conclusion that when you’re writing a report for doctors it’s helpful for us auditors to do some of the thinking for them. (Let’s face it, we do it for most of the rest of the audit process, so why stop at the report writing stage?). If we’re reporting to managers, then lots of pictures help, as does including a wordsearch or dot to dot game somewhere – you know how bored they get.

To make audit reports more exciting (they can be) and more enjoyable (don’t laugh – I have had Trusts write to me telling me they enjoyed reading my report), I think we need to make sure our audit reports are neither Bradshaw nor Whitaker. Tables and graphics are essential, but let’s at least point out what the data suggests to us, whether the findings imply good or bad practice, and what the implications for patient care and risk are. When Holmes finally uses Whitaker to decipher the letter he has been sent he says, “There is our result – and a very workmanlike little bit of analysis it was!”

Put, a sock in, it

A rant about punctuation. Many have written and I won’t bore you with what they have said, but here’s the rant – Why can’t we make sure we know the basic rules of English grammar so that anyone reading an audit report is clear what we mean? Give you an example: Get a pen and write this down and give it to a man (if you are not male yourself) and ask him to note the reactions: (write it down exactly as printed):

A WOMAN WITHOUT HER MAN IS NOTHING

If you are really careful and give this task to a man you don’t particularly like, you may never see him again since he will have been cornered by a crowd of women (first time in his life) and had his intestines replaced with the latest free tote bag attached to the front of the October edition of Marie Clare. (Same function as intestines [a bag for carrying food in], just more trendy to look at). When you have finished celebrating, or if there is some man you fancy, add just two pieces of punctuation to the sentence. Add a colon (back to the intestines – I knew there was a link) and a comma. You then get this:

A WOMAN : WITHOUT HER, MAN IS NOTHING

Changes the meaning completely doesn’t it? Look , I’ve got to go and take my medication now and I can hear the nurse coming, so can I leave you with these final thoughts until next time?

When writing an audit report, ask yourself:

- Is this language comprehensible?
- Is the message being communicated effectively or not?
- What effect is this language having on me?
- Does it stimulate me, making me think?
- Does it make me want to respond?
- Or does it make me switch off and wish I were somewhere else?

Finally, Gary Day, principal lecturer in English at De Montfort University, once wrote in the Times Higher Educational Supplement;

“There’s no greater way to win the respect of your peers than to write in gobbledegook. The less they understand the more clever they think you are”.

Let this not be a maxim for your audit reports!

Signposting

Clinical Audit Today would like to draw your attention to the following events that are taking place later in 2009.

If you are holding an event in 2009/10 and would like this featured in a forthcoming issue of the *Clinical Audit Today* journal, please send details to info@clinicalauditsupport.com

Healthcare Events

is the leading organiser of healthcare conferences in the UK

We research and produce over 150 conferences a year to support professional development and provide a forum for the discussion of new developments and best practice

Quality Indicators and Metrics

Date: Thursday 17th September 2009
Venue: Manchester Conference Centre, Manchester

Clinical Dashboards

Date: Monday 21st September 2009
Venue: 4 Hamilton Place, London

Measuring and Monitoring Clinical Outcomes

Date: Wednesday 23rd September 2009
Venue: 76 Portland Place, London

Lean and Six Sigma

Date: Wednesday 30th September 2009
Venue: 76 Portland Place, London

Patient Reported Outcome Measures (PROMs)

Date: Wednesday 14th October 2009
Venue: 4 Hamilton Place, London

Clinical Audit and Improvement

Date: Wednesday 21st October 2009
Venue: Manchester Conference Centre, Manchester

Risk and Patient Safety 2009

Date: Tuesday 24th and Wednesday 25th November 2009
Venue: Church House, London

Clinical Audit 2010

Date: Tuesday 9th and Wednesday 10th February 2010
Venue: Savoy Place, London

Please quote HCECLINICALAUDITSUPPORT in the office use only box when booking on these conferences

To download a programme or book a place please visit our website www.healthcare-events.co.uk

For more information please call Hanisha on 020 8541 1399 or email hanisha@healthcare-events.co.uk

HEALTHCAREevents
Specialists in health & social care conferences



26th International Conference

The International Society for Quality in Health Care

The Burlington Hotel, Dublin
11th - 14th October 2009



The International Society for Quality in Health Care's 26th International Conference on Quality and Health takes place in Dublin from the 11th to 14th of October 2009.

With the theme of "Designing for Quality" this multidisciplinary healthcare quality programme will be of value to a wide range of professionals, and not exclusively within healthcare. ISQua's 26th International Conference topics will be applicable to countries all over the world. A truly "Global" programme has been agreed. Confirmed speakers include: Sir John Oldham, John Helfick, Sir Donald Irvine, Harry Cayton and Lord Darzi (via video link).

There will be a wide range of presentations and workshops and poster presentation streams include: clinical, quality systems, external evaluation, patient safety systems, education and research, positive patient experience and governance.

For full details of the conference go to: www.isqua.org
email: isqua@isqua.org



Bruce Barraclough
ISQua
President



John O'Brien
Executive
Chair for
Conference

Journal content disclaimer

Please be aware that the views of all authors who appear in *Clinical Audit Today* are not necessarily those of the *Clinical Audit Support Centre Ltd.*