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Audit in Person

When medical audit starts to count

David Bowden, Kieran Walshe

Medical audit has been the least controversial element of the NHS reforms. Its widespread acceptance by clinicians has been encouraging, though it is not surprising that organised medical audit is becoming part of everyday practice for the medical profession. Most clinicians have a genuine desire to prove to themselves and to others that they provide a high quality, effective service. That sense of altruism must never be allowed to diminish.

With a few notable exceptions,^{1,2} however, previous medical audit activities in many hospitals were spasmodic, ad hoc, and uncoordinated. Recent extension and formalisation of audit in most specialties is encouraging because in future medical and clinical audit will be of vital importance to the fate of provider organisations. Whether they succeed or fail will depend not only on their quality of service but also on their ability to prove their effectiveness in terms of outcomes. That is when medical audit will really start to count.

But as medical audit becomes more central to the other major changes in the way the NHS is organised and managed, it in turn will need to be organised differently. There will be an inevitable move towards

clinical audit involving other professionals within the clinical team. Medical audit will be more closely linked to risk management. There will be an imperative to relate quality of care with quantity and cost. More explicit quality standards and outcome measures will be specified in contracts between health authorities and their providers. Doctors and managers will be required to share medical audit information within agreed rules of confidentiality, and, generally, managers will want to show the value of their being involved in the audit process. The box outlines the changes in the characteristics of medical audit which are likely to take place.

Up to now managers have largely watched the development of medical audit from the sidelines, partly because of clinicians' sensitivity about the issue and partly because of managers' preoccupations with a wealth of other changes occurring in the past few years. But as medical audit becomes more important to how they manage their organisation, managers will not be content to be spectators; they will want to be players in a genuine partnership with clinical colleagues. They will need to identify what they can and should do to support the audit process and what they will expect and need from audit in the future.

Past and future characteristics of medical audit

Characteristic	Past	Future
Participation of doctors	Entirely voluntary, so dominated by enthusiasts	Almost compulsory, through peer pressure, job plans, clinical directorates, and contracting process
Participation of other healthcare professionals	Limited participation, except perhaps in data collection	Widespread participation in planning systems and collecting and analysing data
Participation of managers	Little management involvement or interest	Audit central to management objectives; managers involved and interested
Planning and development of audit systems	Uncoordinated, led by individual doctors, lacking comparability	Coordinated by clinicians and managers. Integrated with general information strategies
Resources for medical audit	Little explicitly allocated—dependent on individual commitment	Resources explicitly allocated—both direct and indirect costs recognised
Relevance to organisation's objectives	Peripheral to objectives as defined by review process, authority policies, etc	Central to organisation's objectives, as defined by contracting process. Important for organisation's viability/success
Effect on organisation's performance	Little effect on performance—few changes in individual or group clinical working practices	Measurable and continuing effect on organisation's performance—clinically and managerially

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What managers should do for audit

ENVIRONMENT

General managers have a responsibility to provide the right environment for audit, and, where it does not exist, an obligation to take the lead by giving top level commitment to developing a formal audit process. The experience in this health authority over seven years³ suggests that an incremental, evolutionary and non-punitive, and participative peer review approach is more readily accepted than a system imposed by management. The clinician-manager alliance is therefore crucially important, as is a positive and proactive management style.

The health authority (in the case of directly managed units) or the NHS trust board also has an important role. Not only must it endorse and support the clinical audit initiative but it must also define its priorities in relation to the controversial quality versus quantity argument.⁴ We believe that for those patients who are admitted to hospital the quality of care must not be compromised, even though the overall quantity of treatment and service consequently may be less. This issue surely must be addressed in all hospitals and other units, and a clear policy must be formulated.

RESOURCES

Audit cannot be undertaken sensibly and comprehensively without proper support and allocated resources. The creation of new consultant job plans provides the ideal opportunity for managers to acknowledge the importance of audit by allocating specific sessional time for it as well as set times during the week for senior and junior clinicians to audit their work. This, in turn, will mean the quality-quantity trade off will be made more explicit, maybe with the consequence that previously worked clinics or theatre sessions are forfeited. Resources are also needed to pay for specific research activities and for study leave. Funds must be made available to purchase the necessary information systems and to provide technical and administrative support staff. Medical audit should not, therefore, be seen as a cheap, peripheral activity. It needs time, staff, and money to develop a proper, comprehensive approach. Of course such investments must be shown to result in improved outcomes and better patient care, as well as making the work of clinicians more professionally rewarding.

INFORMATION SYSTEMS

Information systems are a key tool in audit. As the volume and complexity of medical audit activity increase, it will become important that the information needs of medical audit are integrated into corporate information strategies. While the sense of clinical ownership of the information must not be lost, medical audit activities, resource management, contracting,

and other management processes will benefit from the use of a shared database.

INCENTIVES FOR AUDIT

The new contracting mechanism will provide incentives for providers to meet agreed workload targets at lower overall costs than the specified contract price without affecting adversely the quality standards identified. This may be achieved by developing more efficient systems of working, and when costs are reduced the funds saved should be able to be retained for use by the clinical departments concerned. Similarly, we should now be looking at ways to create systems of incentive to reward clinicians achieving proved improvements in clinical outcomes, with the emphasis on recognising improved performances rather than imposing sanctions to penalise under-achievers.

TECHNIQUES

Together, clinicians and managers should be developing and facilitating the introduction of new techniques in audit, such as adverse occurrence screening,⁵ random record review, and criterion based audit,⁶ as well as focused audit studies and an agreed approach to external accreditation and review.

PEER REVIEW AUDIT AND PATIENT SATISFACTION

Managers are required, where necessary, to provide the interface between standard setting based on internal peer review (looking at patient care from within the organisation) and standards of patient satisfaction (looking at the organisation from outside). They should be involved in helping to reconcile the potentially conflicting viewpoints of clinicians and patients on some issues.

CONFIDENTIALITY

With litigation for medical malpractice increasing in frequency, general managers have a responsibility to establish guidelines on confidentiality of medical information within the organisation and outside it. The guidelines should have the twin aims of preserving clinical confidence and using audit information properly. The table shows a model developed by Brighton Health Authority and South East Thames Regional Health Authority for determining the rights of access of different staff groups to medical audit information.⁷

In summary, managers must give a lead, and provide appropriate staffing, funding, and support, to make it easier and more rewarding for clinicians to perform their duties. They should not seek to interfere with doctors' individual clinical judgments but rather to maximise the extent of clinical freedom enjoyed by medical and other professional staff. This is best achieved by managers and clinicians working more closely as partners.

Rights of access of different staff groups to medical audit information

Staff	Information on care or treatment of one patient		Aggregate information on care and treatment of a group of patients	
	Consultant or clinical team identified	Consultant or clinical team not identified	Consultant or clinical team identified	Consultant or clinical team not identified
Consultant or clinical team involved	Complete	Complete	Complete	Complete
Consultant colleagues of consultant or clinical team involved	If agreed by consultant involved	Complete	If agreed by consultant involved	Complete
Consultant manager or clinical director for service in which consultant works	Complete	Complete	Complete	Complete
District Medical Audit Advisory Committee (DMAAC) or similar body	Not normally required	Not normally required	Complete	Complete
Unit or district general managers	Not allowed	Not allowed	As agreed by DMAAC	As agreed between DMAAC and management*

*Unit and district general managers will be given details of the District Medical Audit Advisory Committee's forward programme, an annual report of progress within the district, and regular reports which will be sufficiently detailed to assure them that effective audit is taking place and to identify areas where management action might improve the quality of care.

What managers expect and need from medical audit

ACCESS TO INFORMATION

Managers in both commissioning authorities and provider units need information to determine the quality of the clinical services provided and to assess which clinical activities and treatments actually produce the most effective outcomes. That information should not only identify the standards related to the processes used in the departments concerned but, increasingly, compare the predicted and actual outcomes of those activities. Information is also required to allow managers to assess how well the audit programmes are working and whether they are meeting the objective of producing better patient care. While most managers will be committed to supporting audit they will be reluctant to see resources devoted to it if it does not produce measurable benefits for patients.

AUDIT IN CONTRACTING BETWEEN PURCHASER AND PROVIDER

Without doubt, the health authorities, as commissioners of clinical services, will establish progressively more advanced quality standards in the service contracts they agree with provider hospitals and community services. General practitioner fundholders will also have similar aims in their contracting process. This will force the providers to demonstrate not only that they have formalised audit programmes in place but also that they meet the jointly agreed treatment standards. Providers that cannot match these expectations may well not be asked to provide the services in the future.

AUDIT AND MANAGING THE ORGANISATION

The inevitable development of clinical directorates will gradually see the natural withering away of the cogwheel divisional committees. This will provide an increasingly more powerful position for doctors within the hospital or unit. They will be empowered with more control and authority for managing the resources used within their directorates, and collectively the clinical directors and consultant managers, as members of the unit management team, will influence much more directly the running of the whole organisation. The clinical director is pivotal to the management of the service as he or she combines professional knowledge with managerial clout. But the directors need medical audit information to support their decisions and actions. Audit has been the missing third leg of the resource management tripod which relates activity or workload to costs and quality. The general manager will expect to see all three elements being managed together within directorates, with medical audit and management of resources converging to provide real evidence of total value for money. The key to this is that the clinical director should be accountable for ensuring that there is a totally integrated management of quality, quantity, and cost. Cost effectiveness and clinical effectiveness must be linked. Running a directorate more efficiently both releases

and generates more resources, which can be used to maximise clinical freedom. In many ways organisational arrangements are as important as individual clinical practices in determining the quality of service provided.

AUDIT INVOLVING OTHER PROFESSIONALS

Medical audit is part of a matrix of quality assurance systems that includes a range of clinical professionals and assesses a range of aspects of quality of care. Lines of demarcation and strict professional boundaries make no sense; patients cross them all the time. As confidence allows, medical audit should gradually become part of a multidisciplinary, clinical audit system. This should not detract in any way from the importance of medical audit based on peer review, but there is much to be said for moving towards an audit system centred on patients rather than professions.

AUDIT AND RISK MANAGEMENT

With the removal of Crown immunity and with Crown indemnity ensuring that the new provider organisations are legally responsible for all their care, they must seek to eliminate, or at least minimise, the risks to patients (of injury) and to the organisation (of litigation). Audit has a preventive role in this context and risk management is a natural extension of audit. Risk management programmes are designed to identify and reduce actual or potential risks to patient safety so that patient care is improved and negligence claims are restricted. General managers will wish to ensure that such programmes are developed and that medical audit systems relate closely to them.

In conclusion, medical audit is going to matter in future—to managers and clinicians in provider organisations, to commissioning authorities, and to patients. It will be crucial to the success and viability of providers in the new NHS, therefore managers and clinicians have to work together in provider organisations to develop their medical audit programmes. Doctors should seize this opportunity to be much more involved in shaping provider services, as a key part of a multiprofessional team. Managers should rise to the challenge of becoming better educated and better informed about the work of their clinical colleagues. Between them they can make medical audit start to count.

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