# Clinical audits can work if they are followed up correctly

**Sir,**

In their article 'Clinical audit does not work, is quality improvement any better?' (vol 79(9), 2018, p. 508; https://doi.org/10.12968/hmed.2018.79.9.508) Boyle and Keep concluded by asking whether clinical audit is worth the expense. I would suggest that it is, and it can work, because the audits described do not appear to be at fault.

Between 1983 and 2005, as a Fellow of the Institute of Quality Assurance, I carried out countless quality systems audits against a variety of standards in a range of businesses. These audits addressed: are the correct procedures being followed, are the products and services delivered to the customer's satisfaction, and if not what action is being taken to prevent the fault reoccurring?

Over the past 5 years I have studied some of the worst patient outcomes in the NHS (e.g. Francis, Berwick, Kirkup) and have published a book explaining how improvements can be made using problem solving as a quality improvement tool (Collins, 2018).

Boyle and Keep make a case that improvements do not arise from clinical audits because they are 'entirely focussed on the initial data collection phase'. Few generate a positive outcome because there is little 'post audit action'. For any audit to succeed there must be follow-up action, especially when the work is not meeting a published standard, e.g. only about 18–25% of patients with fractured neck of femur receiving analgesia within 20 minutes of arrival. Results so far off target statistics are not needed to see there is a problem.

It would appear that no one was prepared to declare that the status quo was unacceptable. No one was passing judgement.

Had these audits been followed up effectively with a root cause analysis, one or more of several changes would have occurred: new methods, equipment, software, materials, or training and even counselling.

These audits were not a waste of time because serious shortfalls were found in the work being audited, they were a waste of time because no one was prepared to take action. This requires putting the audit findings into a quality improvement programme, finding the causes of the poor outcomes and making changes to training, equipment or methods to be used in future. There appears to have been a lack of commitment in the hospitals audited to make any changes, an observation I can make because I am an outsider. I am sure readers have their own reasons why this was so, but that would be the subject of another quality improvement project.

**JM Collins**
*Retired Fellow, Institute of Quality Assurance;*
*Retired Management Consultant*
*correspondence c/o* BJHM

Collins JM. Problem Solving for Healthcare Workers. Boca Raton: Taylor and Francis. 2018

**Sir,**

Reading the article by Boyle and Keep, my immediate thought was that the audit baiting season was back. A number of recent articles has suggested that audit is ineffective whereas quality improvement represents the future.

On closer inspection the article left me bemused. The authors conclude 'it is time to critically consider whether the effort and expense expended on clinical audit is justified', despite what appears to be a positive narrative towards the Royal College of Emergency Medicine audit programme. It is disappointing to see a publication from 2000 by Johnston et al referenced to highlight why audit is failing. Should we trust 20-year-old data?

Audit is not perfect. I wholeheartedly agree that 'too much effort is put into the initial data collection'. The authors rightly note that the Francis Inquiry led to national audit becoming mandatory, but do not mention the inconvenient truth that national audits missed failings at Stafford Hospital.

More balance is required. For example, the Sentinel Stroke National Audit Programme is an internationally renowned audit that has improved care. 'Quality improvement probably offers a better way to improve care [than audit]' is a reasonable argument, but the authors offer no real-world examples of productive quality improvement projects.

The article informs that the Royal College of Emergency Medicine will be using quality improvement tools alongside audit in future – a step to be applauded. But without robust audit data these tools will be meaningless. Audit might be an easy target, but we should accept its vital and integral role in improving patient care.

**Stephen Ashmore**
*Co-Director*
*Clinical Audit Support Centre*
*Leicestershire LE8 4GR*
*(info@clinicalauditsupport.com)*

Johnston G, Crombie IK, Davies HTO, Alder EM, Millard A. Reviewing audit: barriers and facilitating factors for effective clinical audit. Qual Health Care. 2000 Mar 1;9(1):23–36. https://doi.org/10.1136/qhc.9.1.23

**Sir,**

We thank Mr Collins and Mr Ashmore for responding to our article about the limitations of clinical audit. We are both heavily committed to clinical audit, but we intended to create some debate about its effectiveness. Currently, there is vast effort and cost spent on initial data collection with little evidence of subsequent actual action. We hope that some of the effort and cost needed for data collection can be redirected towards improving processes and systems.

We accept that a well-conducted clinical audit is often a good point to start a quality improvement initiative and that the evidence around quality improvement is surprisingly weak in health care. The lack of improvement from many clinical audits suggests to us that it would be simply untenable to repeat without major changes.

**Adrian Boyle**
*Consultant in Emergency Medicine*
*Addenbrooke's Hospital*
*Cambridge CB2 2QQ*
*(adrian.boyle@addenbrookes.nhs.uk)*
**Jeff Keep**
*Consultant in Emergency Medicine*
*King's College Hospital*
*London*