An evaluative commentary on systems for review and audit at the United Bristol Hospitals NHS Trust from 1984 to 1995

Kieran Walshe[1] and Nigel Offen[2]

[1]Senior Research Fellow at the
Health Services Management Centre, University of Birmingham

[2]Director of Clinical Governance,
NHS Executive – Eastern Regional Office

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Health Services Management Centre, University of Birmingham,
40 Edgbaston Park Road, Birmingham, B15 2RT.
Tel: (0121) 414 3199. Fax: (0121) 414 7050. Email: k.m.j.walshe@bham.ac.uk

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Introduction

1. This commentary on systems of review and audit at the United Bristol Hospitals NHS Trust (UBHT) between 1984 and 1995 has been commissioned by the Bristol Royal Infirmary Inquiry to inform the Inquiry's understanding of the nature and merits of arrangements adopted at Bristol during this period and how they compared with contemporary policy and professional guidance, accepted standards of good practice, and the systems adopted by similar specialist centres or NHS trusts elsewhere in England.

2. This commentary has been produced by Kieran Walshe and Nigel Offen. Kieran Walshe is a Senior Research Fellow at the Health Services Management Centre, University of Birmingham and has been involved in the development and evaluation of audit and quality improvement arrangements in healthcare organisations since 1988. He undertook a number of national research evaluations in this area for the Department of Health between 1993 and 1997. He is a member of the Inquiry's expert witness panel and appeared as a witness before the Inquiry in this regard. Nigel Offen is Director of Clinical Governance for the NHS Executive Eastern region, is a surgeon by profession, has been the chief executive of a large acute NHS trust in Essex, is chairman of the British Association of Medical Managers, and led the development of clinical audit in the North East Thames region in the early 1990s.

3. This commentary is based on evidence already in the public domain, and draws on papers presented to the Inquiry including witness statements and transcripts of oral evidence, supporting documents, and a briefing paper on the development of policy and practice in clinical audit prepared for the Inquiry. We have reviewed papers relating to audit and review at the United Bristol Hospitals NHS Trust selected and assembled by the Inquiry legal team in April 2000. We have not reviewed evidence received by the Inquiry more recently, after these papers were prepared for us by the Inquiry legal team, but such evidence will clearly be included in the Inquiry's wider consideration of the issues covered by this paper. The research on which this report is based was funded by the Bristol Royal Infirmary Inquiry. All views expressed in this report are the responsibility of the authors alone and do not necessarily represent the views of the Bristol Royal Infirmary Inquiry.

4. This review refers to a number of organisations by abbreviations which need some further explanation. UBHT (United Bristol Hospitals NHS Trust) is used to refer to the NHS trust formed in 1991 which incorporated the Bristol Royal Infirmary and other hospitals, and is also used to refer to the hospitals or units which made up that NHS trust before its creation. BDHA (Bristol and District Health Authority) refers to the health authority which was UBHT's main purchaser. Again, during the period under consideration it changed through reorganisation from the Briston and Weston Health Authority, to the Bristol and District Health Authority, and subsequently to Avon Health Authority. SWRHA (South Western Regional Health Authority) refers to the regional health authority to which BDHA was responsible, and which has subsequently been replaced by the NHS Executive's Regional Office for the South West.

Systems for review and audit at UBHT before 1990

5. As a separate paper prepared for the Inquiry on medical and clinical audit[1] has noted, there are a number of different but largely overlapping definitions of audit, quality assurance, quality improvement and review activities. While there is some diversity of method and approach, what unites these ideas is their purpose – which is to identify opportunities for improvements in the quality of health care and to bring about changes in clinical or organisational practice so that those improvements take place. In this paper, references to "systems for review and audit" or to "audit" can be taken to mean systematic approaches to examining the quality of care, identifying deficiencies or opportunities for improvement, and bringing about changes in order to realise those improvements.

6. Before 1990, there is little evidence that systems for review and audit were well established at UBHT, in any systematic or organised form. There was apparently no corporate function or responsibility for audit, no monitoring or coordination of audit activity, and no mechanism either for identifying problems with the quality of care which needed auditing or for bringing about changes in practice where they were needed. UBHT was not unusual in this regard. While a few hospitals and other healthcare

[1] BRI Inquiry Secretariat (1999). Paper on medical and clinical audit in the NHS. Bristol: BRI Inquiry.

providers in the NHS had begun to develop systems for quality assurance, audit or review in the 1980s, most had not done so[2].

7. However, many individual clinicians and clinical teams did engage in some form of clinical audit, and in most hospitals at this time, a proportion of specialties and departments would have been holding regular meetings to discuss deaths and complications, to review selected cases, to present quantitative data on workload and performance, and so on. The level of participation in such meetings varied widely. The limited evidence we have assessed suggests that in some specialties such activities were taking place at UBHT[3].

8. Very little of the evidence presented to the Inquiry relates to systems for review and audit at UBHT before 1990, and this is in part indicative of the absence of organised systems for review and audit at this time.

Responding to national policy: medical audit at UBHT from 1990 to 1993

9. In 1989, a government White Paper introduced a series of reforms to the NHS, including the development of medical audit. The Department of Health issued guidance in 1990 indicating that it would make special ringfenced or protected funding available to health authorities to be used to establish medical audit. It instructed health authorities to establish medical audit committees, develop strategies and plans, and set up reporting mechanisms. It also outlined some of the principles and goals which it saw as underlying the development of medical audit[4].

10. BDHA established a district audit committee in December 1990. It was almost wholly composed of medical staff, and was made responsible to the hospital medical committee. An early decision was taken to devolve responsibility for medical audit and the ringfenced resources for audit to directorates, and the audit committee's annual report for 1990/91 offers no data on the level or use of resources. It expresses concern about the

[2] National Audit Office (1988). Quality of clinical care in NHS hospitals. London: HMSO.
[3] For example, HA(A) 0034 0016-0026.
[4] BRI Inquiry Secretariat (1999). Paper on medical and clinical audit in the NHS. Bristol: BRI Inquiry.

appropriateness with which resources had been used and argues that the committee should supervise and be accountable for these resources[5]. However, the committee's formal remit, which remained unchanged in subsequent years until 1994, was primarily concerned with promoting audit, facilitating its development, advising on audit issues, and reporting on progress. It had few if any formal powers or sanctions at its disposal.

11. In 1991/92, once the United Bristol Hospitals NHS Trust had been established it assumed responsibility for medical audit[6]. Most of the resources given to UBHT to support the development of medical audit (£227,923 in 1991/92) were distributed directly to clinical directorates, in line with the policy of maximum devolution already outlined above. Much of the rest was spent on a range of IT investments, including standalone PC based clinical databases and workstations linked to the hospitals clinical computer system (termed the Medical Data Index and abbreviated to MDI throughout this report).

12. Each clinical directorate had identified a member of administrative or clerical staff to act as an audit assistant, but this role was generally combined with other responsibilities. No data was presented on how clinical directorates had used their audit resources, and it appears that the use of resources was not monitored. Although responsibility for audit had been devolved to clinical directorates, the audit committee monitored audit activity directly in the specialities and departments which made up those clinical directorates, via a system of quarterly and annual reporting forms. Many departments and specialties appear not to have responded, as data is not presented in the report for them. Some departments – such as general medicine and ophthalmology – clearly had quite well developed and established programmes of audit in place by this time, but for others, including paediatric cardiology and cardiac surgery, no data is present on which to form a judgement.

13. The 1992/93 UBHT annual medical audit report[7] shows that about £225,000 was spent on medical audit in that year, the great majority of which (£151,000) was again directly allocated to clinical directorates with no apparent formal monitoring or reporting on its use. A substantial direct investment was made in IT, though this was more focused on

[5] HA(A) 0034 0016-0026.
[6] UBHT 0273 0001-0074.
[7] UBHT 0066 0107-0153.

supporting the audit assistants in directorates. A fairly detailed proforma had been devised on which specialties were invited to describe the audits they had undertaken, what they had found, what standards had been set, and what changes in practice had resulted. This had resulted in some quite good information about the progress of audit in some specialties such as oncology, ophthalmology and anaesthesia. However, once again it appears that many specialties had not provided data, since no information is included in the report on their activities. The report makes no direct comment on the absence of information for some departments and specialties. No data for paediatric cardiology or cardiac surgery is presented.

14. The annual SWRHA annual audit report for 1992/93[8] makes it clear that UBHT's approach to audit was unusual in a number of respects, and indeed it notes that no data from UBHT is included in parts of the report because it was not received, or was not available in a format which permitted its inclusion. In an extensive list of examples of audit projects and changes in practice from around the region, the report only lists a handful of projects from UBHT.

From national to local direction: clinical audit at UBHT from 1993 to 1995

15. In April 1993, funding for clinical audit activities ceased to be ringfenced centrally and distributed via regional health authorities, and was instead incorporated into the general allocations to health authorities, though in most regions there was a transitional year in which both regional health authorities and district health authorities played some role in commissioning audit from NHS trusts. As a result, BDHA assumed responsibility for purchasing clinical audit from UBHT. As the UBHT annual clinical audit report for 1993/94[9] shows, the trust received £262,000 in audit funding during that year, almost all of which (£230,000) was directly allocated to individual clinical directorates. Once again, no data was presented on how that resource had been used by directorates. The report includes a review of arrangements for audit at UBHT which had been undertaken by the SWRHA regional audit team in early 1994[10], and which was critical in quite a number of areas, though no apparent response to those criticisms is described. Once again, the bulk of the report describes audit activities in individual specialties, and some

[8] UBHT 0066 0316-0367.
[9] UBHT 0024 0071-0129.

areas of good audit practice can be identified, such as anaesthetics and ophthalmology. However, no data for paediatric cardiology or cardiac surgery is presented.

16. The SWRHA annual report for 1993/94[11] again contains no data for UBHT. The report contains a number of comparisons of audit arrangements across NHS trusts within the region, in areas such as the use of resources and the numbers of meetings and projects. Because of the devolved structure of clinical audit at UBHT and the limited reporting arrangements put in place by the UBHT medical audit committee, it would not have been possible for UBHT to provide much of this data.

17. In 1994/95, the UBHT medical audit committee, responsible to the hospital medical committee, was replaced by a new clinical audit committee which reported to the trust board. The remit, leadership and membership of the committee were changed, and the 1994/95 UBHT annual audit report shows this transition in progress[12]. However, the devolved approach to the organisation of audit was continued, with the trust's allocation of £318,000 for clinical audit being largely devolved to clinical directorates (£194,500), while the balance was mostly used for IT investment. The report provides some evidence of a more rigorous and planned approach to audit, with the reasons for undertaking audits being much better described and more emphasis being placed on their results. It also notes that despite very substantial investment in IT for medical and clinical audit over several years, only 8% of audits actually used the trust's MDI computer system. A new approach to monitoring audit activities in specialties was adopted, using a categorised system with little textual explanation. As a result, it is much harder to form a view about the value of audit activity in specialties from this report, though it is again evident that many specialties including paediatric cardiology and cardiac surgery were not represented.

18. In 1996, arrangements for clinical audit at UBHT were substantially revised to bring audit resources including both finances and staff together; provide greater central coordination, monitoring and control of clinical audit; and to strengthen the remit of the clinical audit

[10] UBHT 0024 0076-0079.
[11] HA(A) 0167 0001-0103.
[12] UBHT 0031 0009-0060.

committee[13]. While these developments lie strictly outside the scope of this review, it is worth noting that a case for these changes had been formally articulated at least two years earlier by the regional clinical audit team[14], and would have been evident from any comparison of UBHT's audit programme with those in other NHS trusts in the region[15].

Leadership and direction for medical and clinical audit

19. The UBHT audit committee was chaired by Dr Trevor Thomas from its inception in 1990 to early 1994. For part of 1994 it was temporarily chaired by Mr James Wisheart. From late 1994 to 1996 it was chaired by Dr Jill Bullimore. The committee consisted almost wholly of medical staff from its establishment in 1990 until 1994, when it was reconstituted as the clinical audit committee and a number of non-medical clinicians became members. The committee originally reported formally to the hospital medical committee. From 1994 it began to report to the trust board.

20. The evidence from the committee's annual reports referenced above suggests that the UBHT medical audit committee was established with rather limited powers and little influence. It did not control the resources for medical or clinical audit, it had no audit staff working for it, and those on the committee were not the people responsible for clinical audit in directorates. In this position, the clinical audit committee's formal remit was focused on facilitating, supporting, advising and promoting medical and clinical audit. It had no powers or sanctions of its own. Those leading the clinical audit committee could have approached UBHT management and the hospital medical committee to seek changes to its remit, or to the organisation of medical and clinical audit, but it appears that they did not do so until late 1994, when substantial changes were put in train.

21. In reviewing the work of the UBHT medical/clinical audit committee, it is striking that the committee's annual reports referenced above contain no vision of what they wanted to achieve through medical and clinical audit at the trust. There is an almost complete absence of any forward planning, objective setting, or longer term strategic thinking.

[13] WIT 0342 0001-0003.
[14] UBHT 0024 0076-0079.
[15] HA(A) 0167 0001-0103.

The reports suggest a reactive and retrospective perspective, in which the committee was mainly concerned with describing past activity. The UBHT audit committee seems to have offered little leadership in audit within the trust, and not to have seen "leading" audit as any part of its function, either formally or informally.

22. UBHT's medical audit committee adopted a highly traditional conception of the place of medical audit. Its reports referenced above and other evidence[16] suggest that medical audit was conceptualised as mainly or wholly a professional concern, in which doctors would review what they did with other doctors, for which the results would be confidential to those concerned, and from which education and changes in practice would emerge naturally. This is the antithesis of current thinking on healthcare quality improvement, in which multiprofessional collaboration, openness and teamwork, corporate commitment and leadership, and strong systems for achieving and sustaining change are all seen as very important[17]. Even in the early 1990s, the UBHT approach to medical/clinical audit would have been seen as outdated by some people[18].

23. Between 1990 and 1995, it appears that the UBHT management – its chief executive, chair, board, and managers – played very little role in the leadership or development of clinical audit. In the early years it seems that they were deliberately not involved – for example, the only manager allowed to be present at the medical audit committee was not a full member of that committee but attended as an observer. However, in 1993 and 1994, as ringfencing for audit resources ended, one might have expected to see a growing involvement for trust management in clinical audit. However, this was not the case and it seemed that managers continued to be implicitly or explicitly discouraged from getting involved in audit. In effect, the UBHT audit committee was detached from the mainstream of trust organisational and managerial arrangements, and sat outside the clinical directorate and management structures of the trust with no relationship or reporting link to the trust board or other groups.

Resources and support for clinical audit

[16] Oral evidence – T Thomas – Day 62 pages 23-66.
[17] Scally G, Donaldson L (1998). Clinical governance and the drive for quality improvement in the new NHS. British Medical Journal, 317:61-65.

24. In 1990/91, it is simply not possible to tell from the papers referenced above what resources were made available to support the development of clinical audit at UBHT. In the following four financial years, approximately £0.25 million was provided to the trust each year (see table 1). Known funding for medical and clinical audit at the trust over the period 1990 to 1995 amounted to over a million pounds.

Financial year	Resources for medical/clinical audit at UBHT (£)
1990/91	Unknown
1991/92	227,923
1992/93	225,000
1993/94	262,000
1994/95	318,000
Total	1,032,923

Table 1. Funding for medical/clinical audit at UBHT.

25. UBHT was one of the largest acute trusts in the region, with a large number of consultant medical staff. Since funding was distributed in part pro rata to numbers of consultant medical staff, UBHT received more funding for medical audit than any other trust in the region[19].

26. It is not possible to tell from the available papers how most of the resource for medical and clinical audit was used. The majority of the funding was distributed on a formula basis to clinical directorates, but there is little or no data presented on how clinical directorates then used this funding, and how their use of it contributed to the development of clinical audit. It is surprising that BDHA and SWRHA did not seek further information from UBHT about the use of resources for medical and clinical audit for reasons of probity and good financial audit practice if nothing else. It is difficult to see, from the available papers, how or indeed whether this substantial level of funding helped to progress the development of medical and clinical audit.

27. Some proportion of the audit funding was used to employ audit assistants or clerks in most directorates, from around 1991 to 1995. Because of the devolved approach to the

[18] Moss F, Smith R (1991). From audit to quality and beyond. British Medical Journal, 303:199-200.
[19] HA(A) 0167 0072.

management of medical audit resources, it was left to each clinical directorate to specify the skills needed from their audit assistant and to recruit appropriately. In many cases, the role of audit assistant was combined with secretarial or clerical duties, and it was largely seen in that context as a relatively unskilled position. The combining of different roles in a single post made it difficult to assess whether the audit duties of such posts received the attention they deserved or that funding levels suggested they should. The placing of audit staff in clinical directorates left them somewhat isolated from colleagues with similar roles, and made the sharing of skills, coordination of work or development of specialisation difficult.

28. It is apparent that a substantial investment was made in information technology by UBHT, with the intention that the computer systems purchased would support medical and clinical audit. The level of investment is difficult to quantify, but it was probably the largest single area of expenditure from ringfenced audit resources between 1990 and 1995. However, it appears that the MDI system and other investments were not widely used to provide information for medical and clinical audit, and that the value of such systems for medical and clinical audit was increasingly questioned within UBHT from 1993 or 1994 onwards[20]. Problems were encountered with the functionality of software systems and their integration into clinical practice. In retrospect, the investment in IT seems to have given poor value for money, and to have diverted resources which might have been better invested in audit staff and other areas.

Clinical audit methods and training

29. It is clear from the available evidence in annual reports referenced above that in some parts of UBHT there were examples of good clinical audit practice, in departments or specialties which understood and applied the ideas of clinical audit and were successful in producing important quality improvements. For example, the specialties of oncology, ophthalmology, anaesthetics and general medicine all seem to have had active and worthwhile programmes of clinical audit over some or all of the period from 1990 to 1995. In other words, within the trust, there were examples of good practice in clinical audit which could have been used to promote and encourage similar good practice elsewhere.

30. However, it appears that in many specialties, rather less rigorous and effective approaches to medical and clinical audit predominated. For example, unstructured case presentations, discussions of deaths and complications, and reviews of quantitative data on throughput and workload were clearly seen as acceptable audit activities. While this would have been commonplace in 1990 in many trusts, by 1993 or later one would have expected to see a growing use of more explicit and systematic approaches to selecting topics for audit, measuring practice against defined standards, and defining and implementing change[21].

31. Most NHS trusts began by investing little in training in medical or clinical audit, for their clinical staff and indeed for audit staff too, but as the need for training became evident they began to make it a higher priority. It appears that UBHT undertook little or no training for clinicians on medical and clinical audit between 1990 and 1995, which suggests that clinicians were believed or assumed to already have the skills needed to undertake effective audits. Experience elsewhere suggests that this is very unlikely to have been the case. Indeed, other NHS trusts and healthcare organisations elsewhere have found that training clinical staff is a crucial step in developing clinical audit. Equally, it appears that what training was provided for audit staff was very much focused on the use of computer software packages and of the MDI system. There is no evidence that audit staff were offered training in how to plan, undertake, report on and follow up a clinical audit. As a result, it is probable that both clinicians and audit staff learnt about the process of audit largely by doing it.

Confidentiality in relation to medical and clinical audit

32. The confidentiality of medical and clinical audit was often a concern for clinicians, especially in the early days of medical audit. Doctors were often worried that the disclosure of data on clinical quality to anyone other than their peers (or just their immediate colleagues) would lead to hasty comparisons, inappropriate judgements, and further action. There were also concerns that the disclosure of medical audit data to plaintiffs' solicitors in cases of clinical negligence litigation would adversely affect such actions and make them more difficult to defend.

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[20] UBHT 0024 0079.

33. SWRHA produced guidance for NHS trusts on the confidentiality of medical audit data[22] which was restrictive, even by the standards of the time. It essentially limited access to such data to those immediately involved in the clinical audit itself, and prevented its wider dissemination. Although the chair of the audit committee was permitted to see the minutes of audit meetings etc, he or she was not allowed to then use that information in any way that involved further disclosure, a provision which could be argued to limit his or her scope for action in raising issues of concern.

34. It is evident that clinicians at UBHT raised worries about the confidentiality of audit[23], and that the medical audit committee responded to those concerns by being very cautious about providing information on any audit activities to anyone, even within the trust to the trust board and its chair[24]. This rather secretive approach to audit and its results made it less possible for those other than the medical audit committee itself to reach an informed view about the value and effectiveness of audit activities, and to act if necessary on the results of audit. It may have meant that the medical audit committee was less inclined than it might otherwise have been to raise concerns about the progress of clinical audit in particular specialties and directorates with the hospital medical committee, the trust board or others.

Monitoring and reporting on clinical audit

35. The main mechanism by which the progress of medical and clinical audit in UBHT was monitored was a reporting form, which specialties were asked to complete and return to the medical audit committee at regular intervals (quarterly, for much of the time between 1990 and 1995). This mechanism was put in place from an early stage in the development of audit at UBHT, and could have been a useful tool for managing and reporting on the progress of medical and clinical audit. However, it appears that many specialties did not complete and return the reporting forms, and the papers referenced above show no evidence that such non-returns were then followed up. As a result, the trust's annual medical and clinical audit reports for 1991/92, 1992/93, 1993/94 and

[21] BRI Inquiry Secretariat (1999). Paper on medical and clinical audit in the NHS. Bristol: BRI Inquiry.
[22] WIT 0323 0027-0043.
[23] Oral evidence – T Thomas – day 62 pages 45-47.

1994/95 contain data on a subset of specialties, but some specialties (including paediatric cardiology and cardiac surgery) appear not to be represented at all. Those specialties which had not returned information are not identified explicitly in the reports, so the completeness of the data is difficult to determine.

36. The data reported by specialties, along with other information collated by the medical audit committee, was formed into an annual report on medical and clinical audit, which the trust was originally required to provide to account for its use of ringfenced audit funding. It is clear from the papers that the effort of producing these annual reports fell on committee members, who had to do much of it themselves, sometimes with rather limited data to work from and little administrative support. In these circumstances it is perhaps unsurprising that the annual reports do not provide the outside observer with sufficient information to assess the progress of clinical audit within UBHT, or even to monitor the use of ringfenced audit funding, and their usefulness even at the time must be questioned. Though they were of such limited value, the annual reports on medical and clinical audit were still not widely or freely circulated, and it appears that at different times both the trust board and BDHA were not given access to these reports.

37. UBHT medical audit committee reported to the hospital medical committee, rather than to the trust board, from its inception in 1990 until it became a clinical audit committee in 1994. It was not unusual at the outset of medical audit for this to be the case, but it left the medical audit committee disconnected from the mainstream mechanisms for managing the trust. It also meant that the trust board was not regularly kept informed about the progress of medical and clinical audit, and did not have an opportunity to explore this area of activity.

Medical and clinical audit in paediatric cardiac surgery

38. The department of paediatric cardiology and cardiac surgery at UBHT had a tradition of gathering quantitative data about its activities, including limited information about morbidity and mortality and some comparative information about national performance,

[24] WIT 0102 0011.

which is demonstrated in its annual reports of the late 1980s[25]. These reports do not demonstrate that an effective programme of audit (as defined earlier in this paper) was in place, though they do show the department to be evaluating its own performance to some degree.

39. From the inception of medical audit in 1990 to the end of the period being studied in 1995, no data on paediatric cardiology or cardiac surgery audit activities was included in UBHT's annual medical and clinical audit reports. It appears that throughout this period, the department did not return the quarterly monitoring information that the medical audit committee had sought. There is no evidence that the medical audit committee followed up this non-return of data and it seems to have accepted the situation instead.

40. There are some notes and reports of audit meetings held involving paediatric cardiology and cardiac surgery between 1990 and 1995, but they seem to have been sporadic and rather informal, often taking place in the homes of senior medical staff in the evening[26]. There is no documentary evidence that a regular programme of audit meetings and activities was in place, though, for example, witness statements describe the audit activities of the period[27]. It is not possible to assess, from the information available, the quality or effectiveness of audit activities in the specialty.

The role of Bristol and District Health Authority and the South Western Regional Health Authority

41. Between 1990 and 1993, responsibility for monitoring the progress of clinical audit rested primarily with SWRHA, which was also responsible for allocating funds to trusts within the region. During this period, it is evident that little monitoring of the use of these resources was undertaken by SWRHA. The primary (and perhaps only) source of data to monitor the progress of medical and clinical audit in NHS trusts was the annual audit report that each was required to produce. However, as the SWRHA annual audit report for 1992/93 makes clear, some trusts including UBHT either failed to provide a report or

[25] For example, UBHT 0055 0009-0021.
[26] WIT 0120 0383-0410.
[27] WIT 0084 0015-0028.

provided one which did not provide information that SWRHA sought[28]. Nevertheless, UBHT continued to receive audit funding throughout this period.

42. The regional audit team visited UBHT in March 1994, as part of a series of reviews of audit at trusts within the region, and provided a written report on their findings[29]. This appears to have been the first such formal visit, though SWRHA staff involved in medical and clinical audit were clearly aware of the development of audit before that time and, indeed, Dr Charles Shaw who led medical audit at SWRHA was a member of the UBHT medical audit committee. The SWRHA report highlighted a number of concerns about the effectiveness of audit arrangements at UBHT. It pointed to the devolved responsibility for medical audit and the resultant lack of coordination and oversight; the confusion of responsibility for audit between specialty audit leads and clinical directors; the lack of power and influence of the audit committee; the tendency for important quality issues to be dealt with outside the audit arrangements; the anomalous reporting arrangements of the audit committee; the slow progress in moving from medical to clinical audit; the limited involvement of non-medical clinicians in audit; the isolated position, confusion of responsibilities and lack of support of audit assistants in clinical directorates; and the need to question the value of the trust's substantial investment in IT. The report's criticisms do not seem to have been taken on board by or accepted by the UBHT clinical audit committee at the time, though the later reorganisation of clinical audit in 1995/96 did address most of the concerns. Before 1993, it seems that the UBHT medical audit committee was reluctant to accept any involvement of BDHA in audit activities, and was not willing even to allow BDHA to see the annual medical audit report[30]. The UBHT annual clinical audit report for 1992/93[31] shows clearly that the Trust resisted the involvement of the health authority in medical or clinical audit, which it saw as largely or wholly an internal Trust matter.

43. It is evident that when Bristol and District Health Authority assumed responsibility for funding clinical audit activity at UBHT in April 1993, it made efforts to establish working arrangements for agreeing a programme of audit and reporting on its results. There was resistance from UBHT to any BDHA involvement in monitoring or assessing process

[28] UBHT 0066 0316-0367.
[29] UBHT 0024 0076-0079.
[30] UBHT 0067 0083.

quality issues, and an insistence that BDHA should confine itself to measuring and monitoring the outcomes of care[32]. This situation seems to have been accepted by BDHA during 1993 and 1994, though it represented a much lower level of engagement in clinical audit than would have been found in most health authorities[33], and it limited BDHA's ability to use medical audit to either raise or address areas of concern about the quality of care.

Comparing arrangements for review and audit at UBHT to other acute NHS trusts

44. In our judgement, UBHT's arrangements for review and audit in the early 1990s (1990-1993) were less good than those at many other NHS trusts, and from the evidence and our knowledge of and involvement in medical and clinical audit at the time, we would place the trust at that time in the lowest quartile of performance in medical audit[34]. It was not uncommon for teaching hospitals like UBHT to be slow to respond to the development of medical and clinical audit, for a number of reasons to do with the size, culture and complexity of these organisations.

45. UBHT made a slow start in developing medical and clinical audit compared with other NHS trusts, but this was compounded by its early decisions to invest most of its initial resources for audit in information technology and to devolve responsibility for audit to clinical directorates. Both decisions were, with hindsight, unwise. UBHT was not alone in investing heavily in information technology for audit, but it probably spent more as a share of its available resources than almost all other NHS trusts. Such IT investments were often rather unsuccessful in their own terms (an example might be the cardiac surgery department's purchase of the Metasa clinical database system in 1990[35]). More importantly, they prevented investment in other areas, such as appointing clinical audit staff, and providing training and facilitation support for clinical audit to clinicians[36].

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[31] UBHT 0066 0107-0153.
[32] HA(A) 0009 0014-0120.
[33] Rumsey M, Walshe K, Bennett J, Coles J (1994). The role of the commissioner in audit. London: CASPE Research.
[34] Buttery Y, Walshe K, Rumsey M et al (1995). Provider audit in England: a review of twenty-nine programmes. London: CASPE Research.
[35] WIT 0096 0001-0047.
[36] WIT 0096 0002.

46. The arrangements for review and audit at UBHT were quite different from those at other NHS trusts, and those involved in and responsible for audit at UBHT were well aware of those differences. Most obviously, the decentralised organisational model for audit adopted by UBHT was not the norm, though it was not unique. In the early 1990s, about 10% of NHS trusts adopted this approach, while 90% had more centralised models for resourcing, organising, supporting and monitoring audit[37]. However, most NHS trusts soon recognised that the problems of decentralisation and devolved responsibility outweighed the possible advantages, while UBHT adhered to its approach until 1995.

47. The decentralised approach adopted by UBHT had clear disadvantages, which led the great majority of NHS trusts at the time to adopt a more centralised model. Decentralisation fragmented the limited available audit resource and made its efficient usage difficult; isolated audit staff and left them without peer support or proper management; and meant that monitoring audit activity and the use of audit resources was very difficult. Especially at the outset of audit, when understanding of the audit process was limited and it was an innovation in many NHS trusts, decentralisation was a high risk approach to adopt. Advocates of decentralisation argued that it secured greater clinician ownership of audit activities especially in larger NHS trusts, but research at the time found that such ownership could still be achieved through a centralised audit function with, for example, individual audit staff assigned to work with particular directorates from that centralised audit department. The research suggested that "a central audit department of at least a certain size was essential if clinical audit was to be successfully established"[38].

48. Arrangements for review and audit at NHS trusts evolved rapidly between 1990 and 1995, in response to national policy guidance and a range of other pressures which supported the introduction of medical and then clinical audit. As NHS trusts gained resources to support audit activities, developed a cadre of staff with special skills in audit and quality improvement, and gained experience in the processes of audit and review, so many made rapid progress. In our judgement, the rate of progress at UBHT was rather

[37] Buttery Y, Walshe K, Coles J, Bennett J (1994). The development of audit: findings of a national survey of healthcare provider units in England. London: CASPE Research

[38] Buttery Y, Walshe K, Rumsey M, Amess M, Bennett J, Coles J (1995). Provider audit in England: a review of twenty nine programmes. London: CASPE Research.

slower and so, in normative terms, UBHT's position relative to other NHS trusts probably declined between 1990 and 1995.

Conclusions

49. Research suggests that when healthcare organisations establish quality improvement or clinical audit programmes, those programmes reflect the organisational culture and context in which they are established[39]. Healthcare organisations with a strong and shared vision and values, consistent and stable clinical and managerial leadership, good interprofessional relationships, and well established clinical/managerial arrangements seem to have been more successful at making quality and audit programmes work. In contrast, organisations facing major external threats or changes (like mergers, financial problems or reorganisation), where there is weak and ineffectual leadership, with poor relations between managers, doctors and other clinical professionals, and with little clinical engagement in management are much less able to establish an effective quality or audit programme.

50. In a sense, audit holds up a mirror to the organisation, because the audit programme is shaped in the organisation's image and reflects the function or dysfunction to be found there. This means that, paradoxically, those organisations most in need of quality or audit programmes may be least able to make them work. But it also means that the progress of quality improvement or audit activities may provide a useful marker of wider organisational function or health. This, it can be argued, holds true both for NHS trusts and for the suborganisational units like divisions, clinical directorates or departments of which they are made up.

51. This review suggests that between 1990 and 1995, the systems for review and audit at UBHT were not well directed, adequately planned, properly managed, or effective, and that they compared unfavourably with those in place at similar NHS trusts elsewhere. It appears that the investment of over a million pounds in developing medical and clinical audit at UBHT over this period was not well used. Had more effective systems for review and audit been put in place over this period, they might have contributed more to

[39] Walshe K (ed) (1995). Evaluating audit: past lessons, future directions. London: Royal Society of Medicine.

addressing or resolving the wider issues which the Inquiry has been established to investigate.