Injecting some audit into substance misuse services

Beelin Baxter, Stephen Green, Olwen Williams and Woody Caan

The former East Anglia Regional Health Authority initiated a 3-year project beginning in 1993. This aimed to introduce audit skills and to promote sustained audit activity across a diverse group of statutory and independent sector drug and alcohol agencies. Prior to this there had been little interest in audit for this area of care and no good models of practice were available from elsewhere in the NHS which could readily be adapted to the needs of the Anglian services. Eventually 24 agencies collaborated in this project, which introduced a system of reciprocal peer audit between the agencies which was supported by a dedicated facilitator, a programme of auditor training, and an Agency Audit Representative Group to prioritise topics for audit and to agree common standards. Progress was very slow to begin with. By May 1995, 12 agencies had completed an initial audit of 2–4 topics each from a regional menu of 12 priorities. One year later, 12 more services have undertaken such an initial audit and nine out of the original dozen (75%) have completed their first 'audit cycle' with a re-audit of the same topics. There has been an increase in the number of agencies meeting all the standards in their chosen topics, and in the number of topics where all standards are met, wherever those topics have been audited. Two new practice guidelines have also been developed by the agency representatives.

Since *Working for Patients* was published in 1989, the National Health Service has been expected to give audit a key role in ensuring that the quality of *all* patient care met 'acceptable standards'. Although the quality of care received by people with drug and alcohol problems has occasionally figured in clinical audits (e.g. Caan, 1994; Caan & Crowe, 1994), services for substance misuse have rarely taken the initiative in developing audit methodology for their speciality, with the exception of a pilot project undertaken by the 20 drug services in the South West region (Hager, 1993). Awareness of audit methods seems to have lagged behind other areas of psychiatry. For example, in the 57 pages of the Department of Health's (1991) guidelines on clinical management of drug misuse, the word 'audit' never appears and although the word 'standard' occurs seven times, it is never used in the specific sense associated with quality assurance (cf. Joint Centre for Education in Medicine, 1992; Charities Evaluation, 1994; Royal College of Nursing, 1995).

Relative to 13 other Health Regions, East Anglia entered the 1990s with by far the smallest number of full-time staff employed in drug agencies: altogether less than 30 staff of all disciplines, compared with between 60 and 200 full-time staff elsewhere (Institute for the Study of Drug Dependence, 1991). There was a history of external inspections by the Drug Advisory Service (DAS), but no culture of audit was established with the small, geographically dispersed services. There was no Regional Drug Problem Team in East Anglia, which might have served to promote cooperation between local services. In early 1993 the Regional Advisory Committee on Drug Misuse, supported by the East Anglia Drug Workers' Forum (EADWF), proposed a three-year region-wide 'Substance Misuse Services Audit Project' for both drug and alcohol services, including both the statutory and non-statutory sectors. This project was funded by the Regional Clinical Audit Team. The main elements of this funding were for a dedicated audit facilitator (part-time) and the travel and training costs for fledgling auditors within the specialist services. Reorganisation of the regions in 1994 extended the project to agencies in Bedfordshire as well as Anglia: a total of 25 services.

We had feedback after a preliminary report on the first 12 agencies to be recruited (Baxter, 1995) and a workshop for the Royal College of Psychiatrists (Caan *et al*, 1996). We will summarise the final lessons from this developmental project below.

The study

The first months of the project were mainly taken up in information gathering (with invaluable help from Alcohol Concern, the Standing Conference on Drug Abuse and the Regional Clinical Audit Team on setting standards, and from Steve Easton, South West Regional Drugs Audit Coordinator on drug-related audit training).

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Local support from the EADWF forum played an essential role in mediating between services and the project. Once the facilitator (B.B.) entered post in July 1994, three key processes began: (1) selection of the initial topics and agreed standards for audit; (2) recruiting and training of a bank of auditors drawn from among service staff for inter-District reciprocal peer audit; and (3) establishment of a regular programme of multidisciplinary Agency Audit Representative Group (AARG) meetings. To begin with, the project tried an inspectorial approach based on the DAS (now disbanded). The Steering Group found it difficult to focus on specific objectives for the project until issues of regular membership and responsibilities were resolved. However, by January 1995 the project had established a more participatory model of audit, with a sense of 'ownership' by the agencies themselves, regularly supported by a small Project Board. With hindsight, a decisive agent for this improvement was the feedback from the first audit in September 1994.

Figure 1 charts the evolution of the project over three years.

Findings

Agencies undertook to audit between 2–4 topics (median 3) from a 'menu' of 12 priority topics against explicit standards agreed with all the participants and monitored with the help of their peers from other Anglian Districts and the facilitator. Between September 1994 and May 1995, 12 agencies completed an initial audit, including a report. Only one of these agencies met all their expected standards, most of which were 'minimum' standards of care. Twelve more agencies were involved in some audit activity by May 1996, giving a total participation of 24, 96% of the identifiable services. Forty-two staff received training in audit methods and a bank of 39 workers was available for reciprocal help across the agencies involved. Both statutory (13) and independent sector (11) services have taken part, including two residential units. The aggregated findings of initial audits from 22 services have been reported so far. The four most audited topics have been Confidentiality (21 services), Initial Assessment (9), Waiting Time and Working with Under 16s (6 each). The AARG has agreed guidelines on conducting home visits and prescribing. Agencies have begun to develop their own standards, for example about outreach and drop-in services. After the initial audits, services introduced a number of modest changes to practice. Examples include altering the location or acoustic milieu of interviews to improve patient confidentiality and introducing a formal assessment procedure for under 16s to enable a service to engage with these young users.

Re-audits were expected one year after the 12 initial peer reviews. Nine out of these 12 agencies (75%) have reported a re-audit so far, involving 11 topics in a total of 30 audits. Improvements after one year were observed in 11 out of these 30 topic audits (37%), with services meeting all their targets increasing from one to four out of nine. No deteriorations were observed. The number of topics where all the standards were met had risen from one to nine out of 11 (82%).

Agencies sometimes chose topics for which standards have not yet been developed. In such cases (13 topics) a review has begun and this could generate standards which can in turn be audited. Such reviews included services for pregnant drug users. Independently, the participants at the Royal College's Clinical Audit in Psychiatry workshop (Caan *et al*, 1996) generated a very similar list of topics needing audit, including topics that only an experienced group of auditors should undertake. Standards of follow-up after discharge from detoxification were an identical concern for the AARG and the workshop, and most of the remaining topics from both sources related to communication (with clients, with part-time staff, with other types of service). In both settings some issues like audit of residential rehabilitation in therapeutic communities were considered desirable but very difficult. The workshop did suggest one straightforward area for novice auditors which had never arisen from substance use services by themselves: the uptake of vaccination for hepatitis B.

Comments

At the beginning, staff in almost every service were reluctant to undertake audit of their practice, but it was possible eventually to recruit almost every service, and to observe the audit cycle being completed in 75% after one year. This compares well with other clinical specialities in the Oxford Region where only 47% of published papers on audit have suggested even a hypothetical re-audit (Ellis, 1995).

However, when central funding (from the disbanded Regional Health Authority) ceases, there is a risk that audit in substance misuse might unravel, without becoming a sustained engine for developing practice. This is especially a risk for quality in the non-statutory agencies. Even within NHS Trusts, all of whom have some audit staff, the priority for maintaining audit of drug and alcohol care is usually very low, as their Health Authority contracts are unlikely to specify any audit for such services. Future

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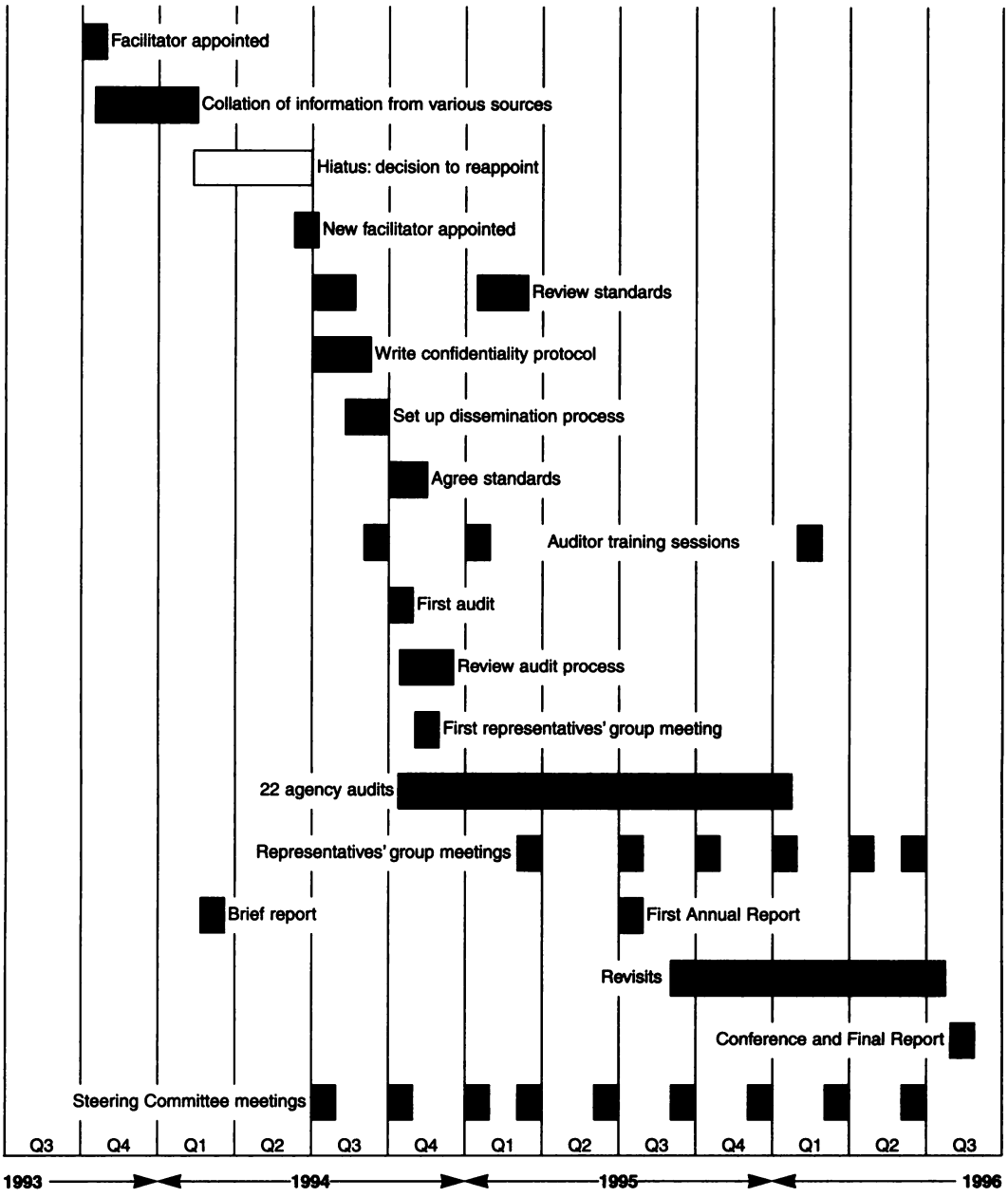

Fig. 1. Project plan

possible sources of audit advice for small specialities have been identified, however. The College Research Unit and the Clinical Audit Association proved to be popular suggestions at our workshop, as well as local forums linked to academic units (such as in the London School of Hygiene and Tropical Medicine or Birmingham University), including some personal contacts with "experts" through professional bodies and conferences.

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The report of the *Task Force to Review Services for Drug Misusers* (Department of Health, 1996) has just been published, whose evidence may provide a powerful incentive to re-examine the quality of care in all agencies for substance misuse. For example, one conclusion of the report reads: "At present the potential of systematic monitoring to ensure services are effective and focused, and to learn from experience, is not being realised". If clinical audit is to thrive across the wide range of such services in the UK, it will be vital to get quality improvement on the agenda for the new Drug Action Teams in each county. The Task Force notes that supra-district services for drug misusers will be adversely affected by the demise of Regional Health Authorities as noted above, and recommends a lead purchaser system. This has been adopted for the Regional Clinical Audit Team in Anglia, but all purchasers will need to be persuaded of the value of audit in this speciality in order to provide funds for its continuation.

Conclusions

With sustained facilitation, staff training and reciprocal help between small agencies, clinical audit can enter the practice of drug and alcohol services and they can improve their professional work. To maintain and ultimately extend the range of audit activity in the future will need recognition and commitment at Health Authority (purchaser), county (Drug Action Team) and national (Royal College) levels.

Details of the A&ORE conference *Peer Group Audit* and the *Final Report* are available from Beelin Baxter, at the address below.

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