



# HQIP End of Award Report for The Health Foundation

Evaluation of quality improvement workshops for clinical audit professionals; lead clinicians and those participating in national audits funded by The Health Foundation, hosted by HQIP and facilitated by Berkshire Consultancy Ltd.

September 2011

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## EXECUTIVE SUMMARY

### Background

This report covers the work funded by The Health Foundation and carried out by HQIP and Berkshire Consultancy Ltd between October 2010 and June 2011. The grant consisted of £100,000 and was used to develop, implement and evaluate a series of regionally held workshops. These were designed following engagement with several NHS Trusts that had identified specific areas of difficulty with raising the profile of clinical audit within their organisations and ensuring that clinical audits improved the quality of clinical care as well as reporting on existing practice.

### The Project

Four styles of workshops were held in eight regions. The topics included: developing a clinical audit strategy; influencing clinicians; quality improvement techniques and tools and local improvement following national audit participation. The demand for these workshops was higher than anticipated especially from clinicians.

The training sessions were open to NHS employees and free for all delegates. Attendees consisted of clinical audit professionals and clinicians. Most of the latter were doctors but nurses, therapists, pharmacists and paramedics also attended.

Each workshop was led by consultants from Berkshire Consultancy Ltd and co-facilitated by HQIP staff. HQIP was responsible for locating venues; advertising events; managing applicant waiting lists and providing all necessary information to delegates. Workbooks were provided to delegates in hard copy on the day and sent electronically, with certificates of attendance after the events. This was to enable those that attended to share the learning back in their organisations. Delegates completed an evaluation form and action plan on the day of the workshop, impact analysis was carried out through email and telephone calls to assess whether the individual action plans had been implemented

### Findings

Throughout the project and on completion the effectiveness of the sessions was evaluated. This was carried out through presenter and facilitator impressions, evaluation forms and the impact analysis process.

- Overall, the workshops were very well received and in many cases actions were either in the process of being implemented or had been already. However, there were a significant number who stated they were unable to make the changes they wished to owing to the fact that their organisations were undergoing huge structural changes, some were going through mergers and others were re-structuring in order to reduce costs and increase efficiency.
- There is clearly a demand from clinicians for learning more about quality improvement techniques. The workshops were heavily oversubscribed and although the number of delegates per workshop was increased there remains an unmet demand in this area.
- Many of the clinical audit specialists who attended did not feel that the organisational structure enabled or allowed them to work closely with clinicians to improve practice. These individuals

would value the opportunity to work with clinical audit leads and other members of clinical teams to help close the audit loop through developing ways of turning recommendations into actions.

- The importance of support and networking within and between organisations cannot be overemphasised. Clinical Audit Leads rarely know how to identify their counterparts in neighbouring or same sector organisations and yet recognise that this would be very beneficial. Clinical audit professionals do tend to know each other through regional networks, however, there is a clear benefit from two or more auditors from the same organisation attending training sessions together, especially if the learning involves changing ways of working.

### **Continuing the Learning**

This project has provided some key lessons for those wishing to provide education and training in quality improvement. Learning from this project suggests that wherever possible training should be provided locally and be free to NHS staff. Funding for training is very difficult to obtain in the current NHS climate, particularly for non-clinical staff. However, workshops can be run cost effectively through comparing local venue costs, keeping the number of presenters and facilitators as low as possible and the number of delegates per workshop as high as possible. It is also possible to get some guest speakers to present for travel expenses only.

Perhaps the most important lesson would be to base the workshop content according to the current financial climate. For example, a recommendation for any workshop carried out in the near future would be to run a session on how to improve quality in a time of change.

## SECTION 1 – Evaluation of Project

### Original Objectives of Award

- a. To facilitate implementation of improvements amongst local level staff engaged in clinical audit in health services in England
- b. To develop the capacity and skills of audit teams to facilitate implementation of improvements following national audit

### Description of the Project

Facilitation of the implementation of quality improvements arising from national and local clinical audit  
Proposed activities as follows:

- Six regional workshops for clinicians on how to manage changes in practice in line with clinical audit recommendations
- Nine regional workshops for NHS healthcare providers on effective strategy development
- Nine regional workshops for clinical audit specialists on identifying and overcoming communication barriers with clinicians
- Two events on how to ensure improvement can be made locally using the results from national audits

The workshops were designed to provide attendees with information and skills that they could then take back to their organisation to use themselves and to share the information with their colleagues. To this end electronic copies of the workbooks and presentations were supplied to all those that attended.

### Main findings

#### What we did

Six regional workshops were held for clinicians on quality improvement methods; nine workshops on strategy development and nine workshops for clinical audit professionals on how to influence clinicians. These workshops were developed for an optimum capacity of 15-20 delegates each. HQIP and Berkshire Consultancy Ltd decided upon the contents of these workshops jointly using the learning from the demonstration project carried out in 2009/10. HQIP managed the logistics of the workshops and facilitated the meetings. Representatives of Berkshire Consultancy Ltd led the workshops and ran most of the sessions, teaching the delegates about various techniques and tools they could use to improve communication between teams and ultimately the quality of care provided by their organisations. HQIP

Quality Improvement Facilitators ran some of the sessions and were present to inform delegates where they could access further guidance and support on quality improvement. For the clinicians workshops we also introduced sessions from HQIP clinical champions who described how they worked as clinical audit leads within their own trusts.

Two larger workshops were held in May (50 delegates each) that concentrated more on how to implement local change following national audits. These were co-facilitated and led by HQIP and Berkshire Consultancy Ltd with guest speakers from national audit providers and local organisations who had successfully implemented improvements using national audit results. Berkshire Consultancy Ltd also ran two sessions on stakeholder management and quality improvement tools.

Attendees of all the workshops received electronic copies of the workbooks used during the day and the presentation slides. Attendees were encouraged to use these electronic copies to cascade the training within their own organisations thereby increasing the learning.

Logistics and costs of running regional workshops

For each workshop there were three facilitators. This consisted of a HQIP facilitator and two consultants from Berkshire Consultancy Ltd. Guest speakers were used for the national audit workshops and the clinician workshops. The cost of engaging guest speakers ranged considerably. Those from the Royal College of Physicians charged £450 per day; clinical champion costs ranged from expenses only to £250 per half day; those from local organisations who had been involved in national audits covered travel expenses only.

Workshops were held at local venues that needed to be easily accessible by rail and road; able to provide rooms large enough for the delegates to be able to sit at tables; good acoustics and able to provide refreshments and nutritious lunches. The cost of hiring these venues varied from region to region with London being the most expensive. However, as London is the most accessible city in England for rail travellers as well as a highly populous area, it is necessary for some workshops to be held in the capital. HQIP were able to reduce costs by utilising NHS Trust facilities for two of the London workshops.

Example of direct costs of a clinician workshop for 25 delegates:

	Cost in ££s
Berkshire Consultancy Ltd @ £1200 per consultant	2400
HQIP Quality Improvement Facilitator	200
Clinical Champion	250
Venue plus refreshments (mean cost of the 6 workshops)	630
Travel / Overnight expenses for presenters	520
<b>Total</b>	<b>4000</b>

*NB: This does not include development costs or printing and transporting of workbooks*

## What we found

There were five main themes that emerged from this project

### **1. There was a much higher level of interest from clinicians than anticipated**

This is the most important finding for both HQIP and The Health Foundation. There is clearly a high number of clinical staff who wish to expand their skills in quality improvement techniques. We received over seven applications for every available place. In addition to this the workshop evaluations demonstrate a need for not just repeats of these workshops but also more in depth support and guidance in leading and managing effective change (see separate section on engaging clinicians for further details).

### **2. Many clinical audit professionals do not feel empowered to work with clinicians to manage change**

In some trusts clinical audit teams are involved in the full audit process but in many organisations their roles are confined to helping clinicians with planning an audit; data collection, analysis and presentation only. The audit department is then responsible for getting a copy of any resulting action plan and giving a date for re-audit. In the more successful trusts, where audits result in improvements in practice, there is both a strong clinical lead and a clinical audit team experienced in working with clinicians and showing them the techniques that facilitate change. Although we were able to provide clinical audit professionals with some basic skills in quality improvement, it was clear that not all delegates would be able to implement these new skills because of the structure of their organisations.

### **3. NHS trusts across healthcare sectors are undergoing huge levels of change**

During the impact analysis phase of the project, a number of those interviewed/ emailed stated that they were unable to put their learning into practice or share it with colleagues because either their organisation was merging or re-structuring. The implication of this is that quality improvement cannot take place during re-organisation. Changes in the NHS are likely to increase further over the next few years; therefore how to ensure quality improvement is maintained during periods of extreme change could be an important area for The Health Foundation and HQIP to investigate further.

### **4. Two delegates are better than one**

Although one senior clinician can take the learning back to their organisation and effect change, clinical audit professionals feel more empowered when they attend with a colleague. This theory was put forward by Berkshire Consultancy Ltd during the planning phase and clinical audit professionals were encouraged to

attend in pairs. Although there is not enough data to show cause and effect, the impact analysis does show a correlation between improvements being implemented locally when two or more individuals from the same organisation attends these types of workshop. It allows for individuals to discuss their interpretations of the learning and provides stronger levels of persuasion with colleagues who did not attend.

#### **5. Importance / requirement of networking**

During group work and breaks, delegates were given the opportunity to network with each other. Both groups of attendees stated that they found this beneficial, therefore as an immediate step, and with delegate consent, email addresses of all attendees were provided per workshop. It has also been identified that since the workshops existing clinical audit professional networks memberships have increased and HQIP are in the process of piloting a network for clinical audit leads in the North East.

### **Challenges**

There were four key challenges that needed to be addressed during the project. Two of these were logistical and two were external to the project but prevented the learning from the project to be fully realised.

#### **1. Oversubscribed Workshops**

There were 120 places available in the workshops for clinicians and these were oversubscribed by 733. There were 360 places in total for the two types of workshops designed for clinical audit professionals and these were oversubscribed by 163. HQIP expected that we would have to use a waiting list for the *developing strategy* and *influencing clinicians* workshops but had, in fact, planned several other methods of increasing the number of clinicians attending and had identified not getting enough interest as an amber risk in the original project plan. We managed this issue by informing clinicians as soon as possible whether they were or weren't successful in gaining a place and creating a waiting list of those that would be able to accept a place at short notice (many doctors would not be able to do this owing to the need to give 6 weeks' notice if cancelling a theatre session / out-patient clinic.)

#### **2. Time scale between workshops and impact analysis**

Owing to the need for reporting on this project pre-August 2011, the time-scale between some of the workshops and the impact analysis phase was not enough to demonstrate the true extent to which the learning had impacted on the individual delegates and their organisation / clinical practice. Indeed, some of

the more strategic plans written by attendees had completion dates of 2012. In order to overcome this and gain as much information as possible HQIP devised a number of strategies for collecting information taking into consideration the job role of the delegate and the time between workshop and analysis (see Impacts / Outcomes section for detail)

### **3. Perceived Change in trusts reduce capacity and capability for improving practice**

During the impact analysis phase it became apparent that many individuals felt that they were unable to use the knowledge gained because of larger organisational change occurring within their NHS Trusts. Although this is a challenge that could not be dealt with directly within the remit and timeframe of this project it remains an important challenge for quality improvement facilitators. Given these circumstances, delegates who were experiencing these difficulties were reminded that they had the tools (in the form of electronic copies of the workbooks, slides and strategy templates) and could therefore utilise these at a later time.

### **4. Some attendees too junior to utilise learning**

In the case of the 'strategy development' and 'influencing clinicians' workshops a small number of delegates had been asked to attend by their managers but many of these were either too new to clinical audit or too junior to be able to process what they were being taught, thereby reducing the cascade effect hoped for. This issue was highlighted fairly early on and was managed through a change in the way we advertised subsequent workshops. The later adverts gave more clarity on the content of the programmes and an idea as to who they were primarily aimed at.

## **Impacts / outcomes**

Impact analysis was carried out for the four different types of workshop. As stated previously, analysis was limited by the length of time between the workshop and the need to report back to The Health Foundation. At the end of each workshop participants were given 15 minutes to write an evaluation of the workshop and devise a plan of action on how they would implement what they had learned back in their organisations. Through the use of carbon paper the delegates were able to keep a copy as were HQIP.

### Clinicians' Workshop

We received a total of 109 evaluation forms from the six clinicians' workshops. Intended actions varied greatly between delegates. Some intended to use what they had learned in a strategic way by becoming more involved in the development of trust strategies, policies and audit programmes; others focussed more on the need for collaboration and communication within and between teams and some focussed on specific quality improvement tools and intended to introduce the use of PDSA cycles and / or driver diagrams.

These workshops ran between January and March 2011, impact analysis took place in June. When deciding on how best to engage with this group we had two main aims: to gain as much information as possible and to be as least intrusive as possible into their daily work. Therefore, it was decided that for this group it would be best to contact them via email, followed by one reminder a week later, although this would inevitably mean a lower response rate.

We received 36 responses of which 20 stated they had been able to implement the action plans they had developed, the following are examples of comments from clinicians who had been able to implement some changes:

"We changed the audit program to reflect the need to show a commitment to improving quality and safety. We now have a rolling program that addresses all of the NICE tags/HQIP minimal standards as well as other areas of interest to our department. The audit program now also includes CPD education as part of maintaining standards." Consultant Anaesthetist, Bristol

"The use of the change [PDSA] cycle had helped me to implement the actions of my audit. This has led to improvement of the quality of care and benefits to my organisation. Changing people's trends and behaviour was the most difficult step, but simplifying the required actions especially with more structured paperwork had lead to encouraging results." Junior doctor, Bristol

Of those that felt they were unable to fully implement their learning at present, this is a fairly typical response:

"There are problems because our organisation is merging- there is considerable turbulence and confusion. I have been reading the National Quality Boards recommendations – we seem to be going astray somewhat.

How do I overcome these times? Focus on what I am able to influence and deliver. Meet with professional colleagues for mutual support focus on the good things- and wait for things to settle down again.” Lead AHP, London

(See appendix A for details)

#### Clinical Audit Strategy Workshop

125 evaluation forms were returned for this workshop. Most of the actions planned involved: developing or reviewing the organisation’s strategy; disseminating it to a wider audience and developing ways of communicating the main aspects of it more efficiently. This group were followed up through a sample group via the telephone in order to gain a more in depth look at how the actions planned were being implemented. In total, 17 telephone interviews took place and of these 11 had implemented their plans; 4 were still in the process and only 2 had been unable to act at the time of the follow up call but still planned to do so. (See appendix B for details)

#### Influencing Clinicians to improve practice

111 evaluation forms were returned for this workshop. The proposed actions followed two main themes: encouraging clinicians to use quality improvement tools such as PDSA cycles and driver diagrams and improving their communication with clinical teams and audit leads. In total 15 people were contacted for telephone interviews. Of this group no-one had been unable to implement their plans; 3 were still in the process and 12 had passed on their knowledge to clinical teams. (See appendix B for details)

#### Implementing Local Change following Participation in National Audits

These workshops took place in May 2011; therefore analysis of the impact of these workshops is restricted to those who have had an opportunity to review national audit findings over the six week period between the workshops and the impact analysis. Emails, which had been personalised with their specific action plans, were sent out to delegates. Thirty six responses were analysed. Of these 20 stated that they had been able to implement the proposed changes. Of the remaining 16, three had begun to implement but were still in the early stages and thirteen had not, mainly because there had been no national audit results released relative to their services in June 2011 or because their organisation was changing its structures.

### **Engaging Clinicians**

The regional workshops for clinicians were held in Birmingham, Bristol, Manchester, York and two in London. The content of these workshops included a short session on the importance of their involvement in strategy development, the importance of involving key stakeholders and how to engage with them effectively and a number of quality improvement tools that they could use to implement improvements to clinical practice following a clinical audit.

We provided for 120 workshop places in total. We received 853 applications for these places. The majority of applicants were doctors; however delegates also included nurses and allied health professionals from all disciplines and NHS healthcare sectors.

HQIP had not anticipated this demand, mainly because it was unprecedented. In our tender we stated that it was clinicians who were ambivalent towards (and less experienced in) clinical audit that we wished to reach through these workshops. It is difficult to assess to what degree this was achieved, however it is clear that many of the attendees were unfamiliar with managing and leading change as can be evidenced through some of their written comments on their main learning points:

“Lots of learning points - now review handout after workshop and my own notes; will think more strategically before setting out on audit; will use some of the information as head of our audit group”  
specialist registrar, London

“Stakeholder mapping - will definitely use this within my practice by getting 'key people' on board; that clinical audit is not just a compliance tool it is a quality improvement tool. Very true for CNST when you have to show compliance – We need to make sure we are actually improving care too!”  
infection control nurse, London

“I need to think 'bigger' in terms of having an audit strategy up front, not just doing the odd audit here and there; excellent ideas for implementing change”  
Consultant Urologist, Birmingham

### **Sustaining the Momentum**

One of the key challenges for us will be maintaining the impetus created by the workshops. We are addressing this in three ways, a) increasing contact between clinicians from different organisations involved in clinical audit b) increasing contact between clinicians and HQIP and c) promoting existing HQIP products and developing more tools specifically for clinicians involved in clinical audit:

### Creating Clinical Networks

There are networks for clinical audit professionals in all regions within England. Most of these meet between two and four times annually and organise annual events where local audits are celebrated and key areas of clinical audit discussed.

HQIP are in the process of setting up a pilot clinical audit network for clinicians in the North East of England. We are doing this in collaboration with one of our clinical champions Professor Mike Bramble and the Chair of the North East Clinical Audit Network. This group will primarily consist of clinicians with responsibilities as clinical audit leads but will also include other interested parties. The first meeting is due to take place in November 2011. This will enable leads from different trusts to communicate with each other and for them to meet with clinical audit professionals to discuss common issues within the North East region. Once this process has been evaluated reviewed and refined, we will roll it out to other geographical areas.

### Contact with HQIP

We have invited clinicians to subscribe to our monthly bulletins and explore the available resources on our website. An illustration as to how effective this has been is a comparison between the number of clinicians registering for the bulletin in the fifteen months between July 2009 and September 2010 which was 56, and the number of clinicians who registered in the eight months between our initial email about the workshops, October 2010 and the last workshops, May 2011, which was 180. Visits to our 'support and guidance' webpage reached 6,832 in the past year.

### Tools and Guidance

During the workshops we discussed, and provided examples of, products relevant to clinicians available from our website: [www.hqip.org.uk](http://www.hqip.org.uk). These included: *Criteria of Best Practice in Clinical Audit*; *Local Clinical Audit: handbook for physicians*; *Guide to Involving Junior Doctors in Clinical Audit*; *Guide for Clinical Audit Leads*; *Clinical Audit: A Simple Guide for NHS Boards and Partners* and *Patient and Public Engagement in Clinical Audit*. We also provided a copy of *New Principles for Best Practice in Clinical Audit* (ed. R. Burgess, 2011) for reference.

In order to continue to support clinicians in ensuring clinical audits are used as quality improvement tools we have produced two e-learning packages that are freely accessible from our website. One is intended for junior clinicians new to audit and the other is for more senior clinicians and clinical audit specialists and focuses on how to ensure audit results are used effectively to improve clinical practice. We are also looking to commission an e-learning tool specific to primary care practitioners comprising of three modules on how to use clinical audit for revalidation, as a healthcare provider and as a health and social care commissioner.

HQIP is currently running six regional workshops on 'how to ensure data quality'. These have been extremely well received thus far and are open to clinicians and clinical auditors.

### **Lessons for the Future**

The delegate evaluations show that the subject of how to improve the quality of healthcare using clinical audit results is a key area for development for clinicians and audit specialists alike. However there is plenty to be learned from this project including what should be repeated and what can be improved.

In the current financial environment it is difficult for all healthcare workers to budget for education and training. This is particularly true for non-clinicians. Many trusts have recently made decisions regarding funding for training events and travel expenses to and from the events. Therefore, in order to ensure attendance any training should be free and delivered locally.

It is vital that the right people attend the most appropriate training. For any future sessions clear descriptions with learning outcomes and a section on for who the training has been designed for should be added to any advertising.

From the impact analysis, it is clear that the training provided interesting and worthwhile information and techniques that have influenced the way clinicians and audit specialists work. However, the content of any further training should also include sessions on negotiation and persuasion in change management. It would also be extremely useful if the focus of the training was based around continuing to evaluate and improve the quality of healthcare during a time of restructure when there is a spotlight on NHS healthcare providers to restrict and reduce resources.

Using the example of costs per workshop, as illustrated on page four, as a crude calculation of costs per delegate then these workshops ran at approximately £160 per delegate. This does not include the designing of the workshops or preparation and distribution of materials, nor does it include the travel and time costs of the delegates. Regardless of how any future sessions may be funded this cost can and should be reduced. The most effective way to do this would be to reduce the ratio between facilitators and delegates. This would involve careful planning so as not to impact on the quality of the training. For this project the decision was made to keep the groups small in order to be able to intensify the input. However, it would be possible to structure the day differently in order to maintain the quality of the sessions whilst meeting the demand and reducing the costs per delegate.

In conclusion, these workshops have had an impact by providing clinicians and audit specialists with tools and methods that can help them to close the clinical audit loop. However, further support is required to enable healthcare professionals to put learning into practice in times of extreme change in the NHS.

**Project Team Members**

Kate Godfrey	National Lead for Quality Improvement and Development	HQIP
Elizabeth Hill-Smith	Consultant	Berkshire Consultancy Ltd
Dr David Gozzard	Consultant	Berkshire Consultancy Ltd
Sue Young	Consultant	Berkshire Consultancy Ltd
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Liz Smith	Quality Improvement Facilitator	HQIP
Mandy Smith	Quality Improvement Facilitator	HQIP
Eleanor Thomas	Quality Improvement Facilitator	HQIP
Alex Bird	Quality Improvement Co-ordinator	HQIP
Adam Smith	Administrator	Berkshire Consultancy Ltd

**SECTION 2: END OF AWARD FINANCIAL REPORT**

**Financial summary**

<b>Amount awarded £100,000</b>	<b>October 2010 - June 2011</b>		
<b>Type of cost</b>	<b>Total budgeted (£)</b>	<b>Total spent (£)</b>	<b>Over/under- spend (£)</b>
Project Manager	12,808	13,201	-393
HQIP Facilitators	28,800	27,230	1,570
Staff Travel & Accommodation	3,125	4,278	-1,153
Berkshire Consultancy	28,600	29,598	-998
Clinical Champions Fees & Expenses	1,000	2,283	-1,283
Events/Workshops	19,000	18,302	698
Production of Resources	7,000	5,256	1,744
<b>Total</b>	<b>100,333</b>	<b>100,148</b>	<b>185</b>

Authorised signatory from finance:

*Joan Shearman*

Print name & position:

Joan Shearman, Business Manager

**2.7 Explanation of over/ under spends in excess of £5,000**

Not applicable

### Clinicians' Workshops

**Evaluation Forms**

n=109

**1. To what extent do you feel that the workshop met your objectives?**

Not at all	Partially	Mostly	Completely
1	14	68	26
1%	13%	62%	24%

**2. How well were you able to use the programme to review your effectiveness in your clinical audit role?**

1 (not at all)	2	3	4	5 (extremely useful)
1	3	21	52	29
1%	3%	19%	48%	26%

not recorded = 3 (3%)

**3. How satisfied were you with the overall organisation of the programme?**

1 (not at all)	2	3	4	5 (extremely useful)
0	1	11	64	33
0%	1%	10%	59%	30%

**4. What were the most useful parts of the programme for you?**

Comments covered 7 main themes:

How to lead and effect change, and change methodology (28)
Quality Improvement techniques (37)
HQIP Clinical Champions (14)
Influencing styles and stakeholder mapping (14)
Personal development, networking, review and time to review and consider (11)
Entire programme (9)
Resources, examples and tools (14)

**5. What were the least useful parts for you?**

69 (63%) of delegates did not comment here. Thirteen delegates felt that the Clinical Champion was the least useful session. *NB it should be noted that this was at the same venue for one individual, this issue has since been addressed.* Most people who named a session they found least useful stated it was because they were already familiar with the subject although 3 went on to say that it was still a useful refresher.

**6. What are your main learning points from the programme, and how will you be able to use these in your on-going development?**

Comments covered 5 main themes:

How to lead and effect change (28)
Techniques for mapping stakeholders and processes, and techniques for implementing change (55)
All aspects of the clinical audit process and its relationship to Quality Improvement (24)
Influencing styles and managing relationships (10)
Networking and time to reflect on, and review, personal practice (10)
Tools provided and signposting to other resources (12)

**7. What are your main actions as you come away from the workshop? What impact do you see these having on your practice?**

Comments covered 7 main themes:

Writing and embedding clinical audit strategy and policy, and improving clinical audit programme and quality of projects (24)
Improving communications including engaging, sharing and involving colleagues (27)
Reviewing and improving change management styles (14)
Identifying stakeholders (17)
Improving personal styles and implement learning (11)
Actively linking with Clinical Audit team (5)
Using PDSA cycles (9)

Anticipated Impact – Comments covered 5 main themes

Improved patient care, experience and safety (14)
Improved engagement in and quality of clinical audit (20)
Improved clinical practice (11)
Improved implementation of change (15)
Improved service delivery (7)

By when – delegates were asked to define timescales for the implementation of their actions responses ranged from immediately to 2012

**Impact Analysis**

Emails, personalised with the delegate’s actions - as taken from the evaluation form, and a questionnaire were sent as follows:

Sent = 93: Responses = 36 (33%)

**Have you been able to implement the proposed changes, as outlined in your workshop evaluation form?**

Yes	No	Other response
20 56%	13 36%	3 8%

The main issues for people being unable to influence change are that

- i) organisations are undergoing change,
- ii) pressure of work
- iii) timescale between the workshop and the evaluation was too short.

### Clinical Audit Professionals

This section covers the two workshops designed to cover:

- i) developing and implementing a Clinical Audit strategy
- ii) how to influence clinicians

These were delivered as separate sessions held on the same day, and in most cases delegates attended both sessions. Attendees completed an evaluation form for each workshop at all venues except for Derby where there was only one form available for both sessions owing to an administrative error. Therefore, the evaluation for the Derby event has been done separately and covers the content of both sessions.

### Clinical Audit Strategy

n=105

#### 1. To what extent do you feel that the workshop met your objectives?

Not at all	Partially	Mostly	Completely
0 0%	17 16%	59 56%	28 27%

not recorded 1 (1%)

#### 2. How well were you able to use the programme to review your effectiveness in your clinical audit role?

1 (not at all)	2	3	4	5 (extremely useful)
4 4%	0 0%	23 22%	47 44%	30 29%

Plus not recorded 1 (1%)

#### 3. How satisfied were you with the overall organisation of the programme?

1 (not at all)	2	3	4	5 (extremely useful)
0 0%	7 7%	15 14%	44 42%	39 37%

#### 4. What were the most useful parts of the programme for you?

Comments covered 7 main themes:

Stakeholder mapping (16)
'Elevator speech' (8)
Strategy content (29)
How to manage challenges (11)
HQIP tools and advice, workbooks and materials (7)
Devising KPIs (11)
Networking, discussion and sharing (26)

#### 5. What were the least useful parts for you?

72 (68%) stated that all aspects were useful. There was no session that came out overall as least favourite. Some comments were from staff who felt they were too junior to get the benefit from this session as they

were not involved in strategy development; three comments about the session being too acute trust focussed.

**6. What are your main learning points from the programme, and how will you be able to use these in your on-going development?**

Comments covered 3 main themes:

Stakeholder mapping and engagement (50)
Elevator speech (23)
Strategy content (including KPIs) and delivery, and HQIP tools (55)

**7. What are your main actions as you come away from the workshop? What impact do you see these having on your practice?**

Delegates planned actions fall within 4 main themes: cascade learning from event to immediate colleagues and wider organisation, develop or review Trust’s Clinical Audit strategy, review key stakeholders and improve relationships and involvement.

By when – delegates were asked to define timescales for the implementation of their actions responses ranged from immediately to 2012

**Impact Analysis**

A stratified sample (n=20) was selected, delegates were contacted by telephone using the same format as the questionnaire designed for lead clinicians.

Contacted =17

Unable to contact = (1 mat. leave, 2 no response to telephone and email message)

**Have you been able to implement the proposed changes, as outlined in your workshop evaluation form?**

Yes	No	Other response (partially)
11 64%	2 12%	4 24%

Yes: Please describe the outcome of the change/s, and the benefits to your organisation, staff and patients.
Plans have been superseded by trust's requirements to have a quality improvement strategy, written by medical director, which will incorporate the clinical audit strategy. Has used workshop learning in consultation process for new strategy document
Make direction of travel explicit and owned; convey key audit messages effectively to wide audience; increase number of allies (email). Provider arm strategy now in place. Has passed on elevator speech technique to team who now use it in a variety of ways. Has also discussed stakeholder analysis with team and will use further as appropriate projects come along. Feels could have some more but restrained by time and other commitments
Attended with lead clinician and also brought document to workshop so has been able to revise, re-order and update strategy, in part using workshop learning.
Reviewed strategy before leaving former trust and now currently working on strategy for new employer. Workshop re-enforced existing learning
Strategy approved and published in April 11. New policy spells out how we link staff on the shop floor with one of five work programmes. Team feels that people are now coming on board and see the benefit on engaging with trust programmes in terms of benefits to them, their patients and the organisation.
Since workshop trust has taken over another trust and therefore needed to merge and align two clinical audit departments, strategies and policies. Still in transitional stage with challenge of legacy issues. Using strategy to bring both organisations into alignment. Using elevator speech techniques when meeting staff from other organisation so she is more focussed on key issues and giving more succinct messages
Strategy had been completed and approved. Plans to develop PPE and link with PALS/PPE group. No problems encountered.
Learnt about HQIP policy and strategy templates. Have used these to write strategy and update policy and include some KPIs. First time have had to do this - so workshop was very valuable. Going to Board for ratification shortly.
Early days yet and trust preparing for FT status - so work in progress; workshop reinforced current practice; have built in KPIs into new Quality Strategy requiring more feedback from board; will be adding drivers to CA training
Strategy now agreed and in place; policy has been written and is currently out for wider consultation - some meetings have already taken place and feedback to date is encouraging
Has met with ADO and line manager. 3 yr audit programme in place. Has not written strategy before but has taken

learning to create CA strategy that also links with other key trust strategies. Has received good feedback from trust clinicians

The only problems encountered related to key people not being available and the need to give changes time to embed.

**No: What obstacles have prevented you in implementing your proposed changes, and how do you plan to overcome them?**

New organisation will come into being on 1 July 2011. Draft strategy, created with workshop learning and HQIP template, is in place but final organisational structure has not yet been agreed.

Leaving current post shortly so it is inappropriate to implement actions as tasks will be taken over by new manager

Four responders reported that they had only been able to partially implement their actions – this was mainly due to organisational changes and the short timescale between the workshop and evaluation.

### Influencing clinicians

n=91

**1. To what extent do you feel that the workshop met your objectives?**

Not at all	Partially	Mostly	Completely
1	19	48	22
1%	21%	53%	24%

Plus not recorded 1 (1%)

**2. How well were you able to use the programme to review your effectiveness in your clinical audit role?**

1 (not at all)	2	3	4	5 (extremely useful)
1	8	17	45	19
1%	9%	19%	49%	21%

Plus not recorded 1 (1%)

**3. How satisfied were you with the overall organisation of the programme?**

1 (not at all)	2	3	4	5 (extremely useful)
0	3	13	44	31
0%	3%	14%	49%	34%

**4. What were the most useful parts of the programme for you?**

Comments covered 2 main themes:

Engaging, influencing and motivating clinicians (16)
Q I techniques including PDSA cycles(31)

**5. What were the least useful parts for you?**

66 (73%) delegates did not comment here. Of those that did 9 (10%) did not like the short role playing exercise and 5 (4%) stated the sessions were too theoretical and not practical, to illustrate this one delegate stated that she thought the session was going to be about engaging clinicians and was disappointed to find it was about communication.

**6. What are your main learning points from the programme, and how will you be able to use these in your on-going development?**

Comments covered 2 main themes:

Q I tools including PDSA cycles and driver diagrams
Recognition of influencing styles and communications strategy

**7. What are your main actions as you come away from the workshop? What impact do you see these having on your practice?**

Delegates’ planned actions are in direct relation to the main learning points above.

By when – delegates were asked to define timescales for the implementation of their actions responses again ranged from immediately to 2012

**Impact Analysis**

A stratified sample (n=20) was selected, and delegates were contacted by telephone using the same format as the questionnaire designed for lead clinicians. Three of this number were also asked to comment on the strategy workshop.

Contacted =15 (two work for the same organisation)

Unable to contact = 5 (1 mat. leave, 4 no response to telephone and email message)

**Have you been able to implement the proposed changes, as outlined in your workshop evaluation form?**

Yes	No	Other response (partially)
12 80%	0 0%	3 20%

Yes: Please describe the outcome of the change/s, and the benefits to your organisation, staff and patients.
Has used workshop learning to support new trust structure that requires Clinical Audit staff to engage more directly with clinicians. Feels more empowered when talking with consultants and teams. Clinicians are pleased to see her and welcome her support
More confident. Feels really successful in work with clinicians, working alongside other staff; feels she is now working in a 'two-way street'; gets more information on issues that she would not otherwise have access to; overall feels more efficient in role.
More able to get action plans from clinicians; able to 'push' more; feels more confident.
Has used technique to planning clinical audit programme for 2011/12 - ensuring that it met the needs of the Quality Accounts and also local priorities.
Has arranged agenda item on Clinical Audit and Effectiveness meeting to feedback on workshop
Clinical Audit is now included in the divisional governance report and driven by divisional structure. Is considering starting quarterly C E bulletin to highlight key organisational issues and learning.
Has used HQIP strategy template which encourages clinicians to take ownership of clinical audit projects thus moving away from the handmaiden role. Still early days yet.
Has put in place quarterly clinical audit meetings in OPD which are progressing well. Has used slides and workshop learning. Works very closely with, and has support of the lead clinician.

Has taken on the learning and now thinks more carefully about how he approaches conversations and his role in discussions.
Early days yet but have meeting in place to review action plans; looking at changing wording of action plan template; considering implementing director level sponsor for action plans
Has reviewed one project and met with participating units to progress audit outcomes; has been useful to revisit existing practises; has renewed enthusiasm; has already seen patient/relative experience improved; will action likewise with other projects; has made contact with SECEN
Early days yet; used learning in recent interview for job - questioned on how to influence clinicians in time of restricted resources; will action plan quality strategy; already encouraging others to think differently; team now know how to use elevator speech and had been used for NICE guidance

The only problems encountered relate to other board priorities, timescale and initial lack of confidence which was later overcome.

Three responders reported that they had only been able to partially implement their actions – this, again, was mainly due to organisational changes and the short timescale between the workshop and evaluation.

### Derby – both workshops

n=20

#### 1. To what extent do you feel that the workshop met your objectives?

Not at all	Partially	Mostly	Completely
0 0%	2 10%	10 50%	8 40%

#### 2. How well were you able to use the programme to review your effectiveness in your clinical audit role?

1 (not at all)	2	3	4	5 (extremely useful)
0 0%	1 5%	5 25%	7 35%	6 30%

Plus not recorded 1 (5%)

#### 3. How satisfied were you with the overall organisation of the programme?

1 (not at all)	2	3	4	5 (extremely useful)
0 0%	0 0%	2 10%	8 40%	10 50%

#### 4. What were the most useful parts of the programme for you?

Comments covered 3 main themes:

Quality Improvement tools including PDSA cycles (5)
Driver diagrams (4)
Strategy development and review ( 4)

#### 5. What were the least useful parts for you?

Eight delegates commented here. Three felt they couldn't use the information received in the strategy workshop owing to on-going re-organisation of their departments / trusts; two didn't like the role play exercise; one person said transactional analysis and one driver diagrams and one individual stated that although facilitating change was interesting they didn't see how they could implement it.

**6. What are your main learning points from the programme, and how will you be able to use these in your on-going development?**

Comments covered 3 main themes:

How to influence clinicians and other, especially difficult people (8)
Map stakeholders (8)
Quality Improvement including PDSA cycles (5)

**7. What are your main actions as you come away from the workshop? What impact do you see these having on your practice?**

Delegates’ planned actions are in direct relation to the main learning points above.

By when – delegates were asked to define timescales for the implementation of their actions responses again ranged from immediately to 2014

**Impact Analysis**

A stratified sample (n=4) was selected, and delegates contacted by telephone using the same format as the questionnaire used for lead clinicians, everyone responded and two worked for the same organisation.

**Have you been able to implement the proposed changes, as outlined in your workshop evaluation form?**

Yes	No	Other response (partially)
<b>3</b> 75%	<b>0</b> 0%	<b>1</b> 25%

<b>Yes: Please describe the outcome of the change/s, and the benefits to your organisation, staff and patients.</b>
Have now found out and met clinical audit facilitator linked to the Infection Control Team; large audit now in progress
Early days but strategy is currently being beefed up. Gradual move towards clinicians taking on responsibility of lead roles in audit; QI - process mapping in place; working with clinicians becoming more effective; training in place to support this
Reinforced existing knowledge. Already had strategy in place but tweaked it slightly following the day; now assured they are working on the right lines. Clinical Audit engagement plan and audit programme in place.

The only problems encountered relate to lack of time and the large size of organisation and how to communicate and embed change.

One responder reported that they had only been able to partially implement their actions – this, again, was mainly due having to break down barriers and conflicting priorities.

### Local Improvement Following National Clinical Audit

**Evaluation forms**

n=73

**1. To what extent do you feel that the workshop met your objectives?**

Not at all	Partially	Mostly	Completely
2 3%	31 42%	34 47%	4 5%

Plus not recorded = 2 (3%)

**2. How well were you able to use the programme to review your effectiveness in your clinical audit role?**

1 (not at all)	2	3	4	5 (extremely useful)
1 1%	3 3%	21 19%	52 48%	29 26%

Plus not recorded = 3 (3%)

**3. How satisfied were you with the overall organisation of the programme?**

1 (not at all)	2	3	4	5 (extremely useful)
0 0%	1 1%	11 10%	64 59%	33 30%

**4. What were the most useful parts of the programme for you?**

Comments covered 7 main themes:

How to lead and effect change, and change methodology (28)
Quality Improvement techniques (37)
Guest speakers (14)
Influencing styles and stakeholder mapping (14)
Personal development, networking, review and time to review and consider (11)
Entire programme (9)
Resources, examples and tools (14)

**5. What were the least useful parts for you?**

27 delegates stated that all of the sessions were useful. However 16 found the local examples the least useful, partly because they were too acute sector focussed and partly because one presenter focussed on the software system used to collect data rather than how changes were implemented. Other comments were that delegates found particular sessions not as useful because they already knew the subject matter (A few delegates had attended the influencing clinicians workshops where some of the sessions were repeated).

**6. What are your main learning points from the programme, and how will you be able to use these in your on-going development?**

Comments covered 5 main themes:

How to lead and effect change (28)
Techniques for mapping stakeholders and processes, and techniques for implementing change (55)
All aspects of the clinical audit process and its relationship to Quality Improvement (24)
Influencing styles and managing relationships (10)
Networking and time to reflect on, and review, personal practice (10)
Tools provided and signposting to other resources (12)

**7. What are your main actions as you come away from the workshop? What impact do you see these having on your practice?**

**Actions - Comments covered 7 main themes:**

Writing and embedding clinical audit strategy and policy, and improving clinical audit programme and quality of projects (24)
Improving communications including engaging, sharing and involving colleagues (27)
Reviewing and improving change management styles (14)
Identifying stakeholders (17)
Improving personal styles and implement learning (11)
Actively linking with Clinical Audit team (5)
Using PDSA cycles (9)

**Impact – Comments covered 5 main themes**

Improved patient care, experience and safety (14)
Improved engagement in and quality of clinical audit (20)
Improved clinical practice (11)
Improved implementation of change (15)
Improved service delivery (7)

By when – delegates were asked to define timescales for the implementation of their actions responses ranged from immediately to 2012

**Impact Analysis**

Emails, personalised with the delegate’s actions - as taken from the evaluation form, and a questionnaire were sent as follows:

Sent = 93 (5 being undeliverable)

Not sent = 16 (4 insufficient contact details, 7 no actions recorded on evaluation forms, 5 others including guests and retirement)

Responses = 36/77 possible returns (47%)

Have you been able to implement the proposed changes, as outlined in your workshop evaluation form?

Yes	No	Other response
20	13	3
56%	36%	8%

The main issues for people being unable to influence change are that organisations are undergoing change, pressure of work, not currently involved in national audits as short timescale between the workshop and the evaluation.