National Advisory Group for Clinical Audit & Enquiries

Consultation on *Future of Audit staff in Trusts*

Summary of respondents' views

Response

The consultation carried out July-September 2012 had an excellent response (66), the majority of which (54; 82%) were from staff in provider Trusts. In addition we were delighted to receive responses from three clinical audit support organisations, five other organisations (a Royal College, a quality observatory, the NHSBT, and two 3rd sector providers), and two doctors. Not every respondent answered every question. We did not receive any responses from suppliers of national clinical audits.

Our intention was to confine our analysis of the responses to a qualitative review of the comments and views expressed. However, in view of the relatively high proportion of Trusts that responded, we have conducted a quantitative as well as qualitative consideration of people's views. This helps to summarise and gain an overall sense of people's opinions. Clearly, however, the quantitative results need to be treated with some caution given that we do not know how representative they may be.

General observations

Before considering responses to each of the 10 specific questions posed, three general observations. First, there was a divergence of views as regards the potential impact of our draft proposals. While most people felt they were radical and would involve major changes (both in structures and functions within Trusts), about a fifth of respondents reported that there was nothing novel in the proposals and that staff in their Trusts were already organised and functioning in the way proposed. This reveals the variation that currently exists and explains some of the differences in views expressed.

Second, some respondents thought that NAGCAE's intention was to establish rules or instructions that would somehow be enforced in every Trust. That has never been the aim. The intention is to explore the extent to which there is a consensus among those involved in clinical audit (locally and nationally) as to the current challenges facing audit staff in Trusts, to understand the underlying causes of any concerns and to suggest ways in which the future might be better for staff, Trusts and the quality of NHS services. The end point of this process will be advice to the NHS Commissioning Board for their consideration.

Third, NAGCAE is aware that existing arrangements in Trusts vary. For example, some Trusts have a designated 'Audit Department' but others do not. This means that some of the issues raised in the consultation document will not be directly relevant for some respondents (eg the advantages and disadvantages of having an audit department). An associated challenge is that terminology will vary between respondents.

Although the ten questions we posed were inter-related, for clarity we will consider each in turn by presenting a brief summary of the responses received. Although the majority of

respondents agreed with the views expressed in the consultation document, we have concentrated on summarising the views that were not supportive. NAGCAE's intention is to modify the draft proposals in an attempt to accommodate dissenting views as much as possible.

Concerns of audit staff in Trusts

Of 64 responses, 55 (83%) agreed with our assessment of the current concerns of audit staff in Trusts although for 13 not all the concerns identified applied to them. For example, some reported that they enjoyed good Board support, had no difficulty in prioritising the competing demands they faced, or did not feel that their involvement in 'other' activities (eg risk management) was an irrelevant diversion.

Most of the 9 respondents who disagreed still recognised the problems outlined but said these did not occur in their Trust.

One principal concern is the perception that 'external' requirements can override local priorities. The requirements of national clinical audits (NCAs) – some of which are mandatory, others an expectation – were considered to distract from locally perceived priorities though others recognised and accepted the value of NCAs. In addition, some NCAs were deemed to be of poor quality and to reduce staff to being data collectors and, as a result inducing a sense of deprofessionalisation.

The other principal concern was a perception that audit priorities increasingly focused on the financial needs of Trusts such as meeting CQUIN and QUIP targets. Orientation to 'cost saving' was seen by many as a problem particularly as such goals was not always consistent with clinicians' priorities.

Three concerns that had not been included in the consultation document were: the need for more national help/support to use NCA output; actual and anticipated reductions in consultants' SPA time for audit; and the loss or diminution of audit teams in commissioning organisations.

Sustainability of status quo

Of 61 responses, 45 (74%) agreed the present situation was not sustainable. Of the 13 who disagreed, 11 stated that audit in their own Trust was sustainable, partly because they had already adopted the sorts of approaches suggested in the NAGCAE document.

The principal reason for non-sustainability was insufficient resources rather than any of the other issues cited in the document. This had led to a loss of audit staff and those who remained had to focus on assessing quality (either national or local audits) with no time available for helping to improve the quality of services.

Other reasons cited were the lack of clear national guidance as regards priorities and activities for Trusts, clinicians' lack of engagement and responsiveness to audit staff, and the loss of credibility with clinicians if audit was dominated by a tick-box culture.

Underlying problems

Overall about 40 (63%) respondents agreed with the suggested reasons for the current situation, though the level of agreement varied a little between the five reasons put forward.

1. Understanding of what 'clinical audit' is varies: the term may be more of a hindrance than a help

Respondents were equally divided between those who agreed that the term 'clinical audit' was a hindrance and those disagreeing. The latter saw the problem as one of misuse of the term and is understanding which could be resolved by clarifying its meaning.

2. Multiplicity of approaches to improving quality is not sufficiently appreciated

Of 63 responses, 38 (60%) agreed that greater understanding of the many ways that audit data could be used to stimulate quality improvement (eg redesign, education, incentives, regulation etc) was needed. In contrast, some of those disagreeing felt that the suggestion that staff in Trusts did not appreciate the full range of uses underestimated their knowledge and understanding.

3. Concept of an 'audit department': creates unhelpful boundaries

Again, a marked division of opinion between those in agreement (32; 52%) and those opposed (23; 37%) with the rest undecided. Many of those disagreeing worked in audit departments did not perceive any problem and could not see any benefits from change.

4. Isolation of audit staff in individual Trusts: risks reinventing the wheel (or flat tyre)

Of 56 responses, most (41; 73%) agreed that they were more isolated than they would wish though for some this was not seen as a major problem.

5. Quality improvement skills and knowledge of clinicians and managers poorly developed

Most respondents agreed (39; 67%) with an additional 12% seeing the problem as more of a lack of interest than knowledge. In contrast, others reported excellent knowledge and involvement from clinicians.

Many respondents suggested that there is a sixth reason for the current situation, some of whom feeling it was the principal problem: the proliferation of national requirements (NCAs, CQUIN, QUIP etc).

A new vision for audit staff in Trusts

1. Explicit definition and recognition of the two key components of achieving quality

Most respondents (47; 78%) would welcome the distinction between quality assessment and quality improvement being made clear. Those disagreeing either felt there was no problem/need as the distinction was well understood or they rejected the notion that there were two distinct components. There was some concern also expressed that the very act of recognising the two components would lead to their separation which would harm clinical audit.

2. Recognition in Trusts of multiple approaches to quality improvement

Although only 60% had said there was insufficient appreciation of the multiple approaches to quality improvement (see Q3 above), 70% agreed greater recognition of the range of interventions was needed.

The 11 (19%) disagreeing felt this was unnecessary as the range of approaches were well recognised.

It was suggested that suppliers of NCAs should take more responsibility for explaining the different ways that the data they generated was being and could be used both locally and nationally to stimulate quality improvement.

3. Greater integration: 'quality is everybody's business'

Most respondents (52; 80%) agreed and accepted that greater integration in all or some of the ways suggested would be helpful in promoting clinical audit. Integration of data collection (ideally with the introduction and use of electronic medical records) was seen as particularly helpful.

Some of those disagreeing reported that they already had well-integrated services so there was no need for further action. Others questioned the benefit of integration (such as considering clinical and non-clinical issues together) and expressed concern that it could endanger clinical audit in several ways: greater focus on safety, complaints and risk management; domination by doctors; and loss of funding to the other components (such as consultants' SPA costs). Integration was also seen as a threat to the methodological rigor of clinical audit.

Others disagreeing felt that the suggested ways of greater integration did not go far enough and would perpetuate the separation between a concern for quality and wider management concerns. Instead what was needed was integration of quality throughout all management and practice in a Trust, a step that would require commitment and leadership from the Board.

4. Supporting enhancements in the roles and responsibilities of audit staff

Most respondents (60; 92%) agreed that additional training and support was needed for all Trust staff involved in assessing and improving quality: audit staff, clinicians, managers. It was recognised that to be successful, cultural change in the Trust would be necessary and this could prove too challenging to achieve.

There were two rather contrasting reasons given by those disagreeing. One was that training was not needed as staff already possessed sufficient skills (in particular, clinicians). The other was opposition to the suggestion that audit staff should adopt a facilitating and advisory role. Instead they should continue in a technical role, otherwise their existing skills will be 'diluted'. There were also concerns that existing audit staff would struggle to take on an extended role or if they did take it on it would lead to a redefinition of their posts which would incur higher pay which their employer would baulk at.

5. Sharing experiences: learning from the best

Most respondents (50; 86%) agreed that much can be learnt through sharing, though this should be voluntary rather than mandatory. There was strong support for more sharing despite several accounts of poor previous experiences of both local/regional and national initiatives

Some questioned why it would work in the future given past attempts. Several reasons for past disappointments were offered: lack of time and resources; senior managers' concerns about sharing 'commercially sensitive' information with 'competitors'; clinical audit staff being possessive about their intellectual property; over-complicated and over-centralised administrative arrangements of networks etc; confusing multiplicity of 'networks'; and lack of strong clinical and senior manager involvement.

Respondents were not always aware of the existing 'regional' organisations that have been or were being established by the NHS to enhance sharing (eg CLAHRCs, HEIC, AHSNs) or there was a misperception that they are geared to research rather than improving the quality of services.

Proposal

1. Recognition and acceptance of four fundamental issues

Most respondents (51; 86%) agreed with these though some pointed out that for them and their organisation, these were already recognised and accepted. Some felt these issues also needed to be recognised by the DH/NCB.

The one issue that the other 14% of respondents did not accept was the need to distinguish between the two key aspects of achieving high quality: quality assessment and quality improvement. A few went so far as to suggest such recognition would demoralise audit staff in Trusts.

2. Development of Quality Departments (or Facilities) in Trusts

Although there was less support for this proposal, 40 (70%) respondents were in favour. Some went further and suggested that R&D and clinical coding staff should be included. It was also suggested that some lay people should be included as should responsibility for clinical governance. Additional responsibilities suggested for Quality Departments included the provision of information for doctors' appraisal/revalidation and approval of FP doctors' audits.

Others (8; 14%) mentioned how Trusts varied and thus arrangements for leading work on quality would need to vary. Some would prefer to disperse responsibility to clinical teams and have no central facility in a Trust.

Those opposed (9; 16%) felt that audit staff shouldn't 'diversify' and an emphasis on facilitating and advising (rather than hands-on data collection, analysis, presentation) would undermine their skills and reduce their perceived value to clinicians and managers. Overall they felt that integration risked clinical audit being 'swallowed up'.

3. Training opportunities

All but one respondent (57; 98%) agreed that there was a need for staff in Trusts involved in assessing and improving quality (audit staff, clinicians, managers) to increase their understanding of national policies related to quality, their technical and their behavioural skills.

A few respondents advocated the need to establish a nationally recognised qualification for staff involved in quality which it was felt would help enhance their status. This should cover core competencies.

4. Establishment of multi-Trust initiatives

This was broadly supported (51; 91%) though it was suggested that such initiatives would require inspirational leadership to be successful. Those opposed were either not convinced of the benefits of networking or anticipated that emerging bodies such as Academic Health Science Networks would prove an irrelevance.

5. National clinical audit suppliers

There was universal agreement of the need for NCA suppliers to increase and improve the ways and extent to which they provide Trusts with feedback on quality and stimulate quality improvement. While many respondents advocated a review of the quality of NCAs with the aim of reducing their number, some wanted more NCAs in areas of health care currently not covered.

Other suggestions

Four other suggestions were made:

- The need for more resources to increase staffing levels and pay higher salaries commensurate with greater skills and responsibilities. In addition, more consultant SPAs devoted to audit were needed.
- Greater clinician engagement: all senior clinicians should be required to be involved in a ‘proper audit’ and in each clinical area there should be nominated lead clinicians committed to quality assessment and improvement.
- Greater integration/alignment of national needs for data assessing quality to avoid Trusts having to meet a variety of different requests.
- Need for standard software for local audit data collection.