National Advisory Group for Clinical Audit & Enquiries

Consultation on Future of Audit staff in Trusts

Responses to the overall document and to the specific questions should be sent to clinicalaudit@dh.gsi.gov.uk) by Monday 17 September 2012.

The full document can be downloaded from www.dh.gov.uk/health/2012/07/audit-staff/

Q1	Do you agree with this assessment of the current concerns of audit staff in Trust?]	Not so much for our trust because we have developed some smart solutions. For example: We use an on-line audit proforma to reach all Quality Accounts audit leads and this includes all NCAPOP.
Q2	Do you agree that the current situation is not sustainable?	We managed to get NHSLA level 3 and that was difficult but we can't complain because a 0.4 member of staff post was frozen for a few months and then replaced with a 0.8 in recognition of the needs in clinical audit.
Q3	Do you agree with this analysis of the underlying reasons for the current situation?]	No not really because I feel myself as manager and all of my team are highly respected for what we achieve. We've been saying for a long time that audit is a way to wave the flag and say look how well we're doing. I don't feel isolated at all. Our Governance Department are very supportive and we seem to have engagement across the trust – there will always be a small minority of individuals who at some time can't return data or for whatever reason struggle to respond to emails but I find it's all taken very seriously. We have invited the 'experts' into the organisation from time to time over the past 10 years, to deliver expert training in clinical audit – refreshing us with the most up-to-date audit training and helping to broad people's knowledge about evidence. We have always recruited Healthcare Quality Quest to do this. Feedback from clinicians has been marvellous.
Q4	Do you agree this would be helpful?	A vision is always helpful and we have one for which every member of staff knows how their own contribution is linked to the 2020 Vision and our own local Clinical Effectiveness Strategy for how we will achieve. The consultation vision looks very good.
Q5	Do you agree this would be	Yes it certainly would be helpful. I think we do

	helpful?	give that recognition and at our annual Clinical Audit Conference we have heard some great presentations about national audits – this was a great opportunity for individuals to see how consultants like to look at their own data and find the capacity for benchmarking a positive process. Better understanding might be particularly helpful to junior doctors who are asked to participate in national audits (data collection). We provide a certificate for participation in clinical audit.
Q6	Do you agree this would be helpful?	Response by bullet point: a) Data collection….yes I agree this is important. b) Clinicians, managers and audit staff…we are closely integrated and find it helpful to explain, if necessary, why it's important for clinicians to be involved in the audit process. c) Organisational structure… no I don't agree and it would be grossly unfair to say our department is isolated. We are very much at the heart of quality improvement and work with the Service Improvement team and Governance, Risk etc. d) Not sure about this. We're such a large trust. Would one department be too big. We do have one big department in a way 'Trust HQ/Governance' What we have is a patient improvement framework (PIF) which is updated each year, and agrees the current top 15 priorities for the organisation (5 patient experience, 5 patient safety, 5 patient outcomes) and we align our clinical audit plans to these ensuring we have the local top priorities covered. It is circulated for consultation and eventually goes to trust board but not until Divisions have added local priorities. e) As a concept I agree completely, but I would not find it beneficial to mix service evaluation with 'clinical' audit. We have to be very smart with our resources and might come unstuck if we required the same processes to be followed for service evaluation as we do for clinical audit. The two often do go together but individuals need to be absolutely clear

		about the differences. f) Clinical care… this is right but quite a resource intensive area in all ways. It is the right approach.
Q7	Do you agree this would be helpful?	Supporting enhancements – this sounds as though it could be helpful and provide opportunities.
Q8	Do you agree this would be helpful?	Shared learning is so valuable but for this to work trusts would need to invest specific time. Can we afford not to? Networks are one of those concepts that probably work best if there is dedicated time within a job description. Engaging with people is more effective than using a website, but it costs. Rewarding trusts for doing well through recognition is very positive/encouraging all round.
Q9	What is your view of each component in the proposal?	1. Agreed as fundamental 2. I agree with the principle but since hospitals vary so much e.g. number of different sites to make up one trust, different services, different pressures. Therefore I would avoid a one size fits all model. 3. I agree with training opportunities. 4. Multi-trust initiatives – good idea. 5. National clinical audit suppliers – agree this is a sensible approach.
Q10	Do you have suggestions for other components?	Standardising where we look for results and the format so we really can easily locate 'site-specific' and 'national' results for every single national audit we submit to. Perhaps a DH 'Framework' for national audits if there isn't one out there yet. The framework could stipulate specification requirements to enable the public and organisations to view national audit results via the Information centre.