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?]	Partly. I agree that there are too many demands from various sources and that resources are insufficient, but I feel that our local audits are supported across the Trust, value for money and have sufficient ownership and engagement from Clinicians. It is the ever increasing HQIP National Clinical Audit list that causes issues.
Q2	Do you agree that the current situation is not sustainable?	Yes. More investment is needed in local clinical audit teams and the National Clinical Audit list that constitutes the clinical audit section of our Quality Accounts document needs to provide more information, such as all relevant dates and eligibility criteria. This would prevent every Trust wasting many hours assessing if they are eligible.
Q3	Do you agree with this analysis of the underlying reasons for the current situation?]	No. Changing the title from clinical audit would lead to increased confusion in Trusts, undermining the work taken to ensure staff understand who we are and how we can help them improve patient care.
Q4	Do you agree this would be helpful?	No. How is this a new vision? We perform a baseline audit, draw up and implement actions from the results and re-audit to assess improvement.
Q5	Do you agree this would be helpful?	No. I agree with the last line "Success in improving quality will come about through a combination of local and national interventions." However, it looks like a means of keeping clinical audit staff continually entering data rather than using their skills to assist more targeted local audit.
Q6	Do you agree this would be	No. I do not think that merging Risk,

	helpful?	Complaints / PALS and Clinical Audit into a Quality Department would be useful. Trends and specific incidents identified from Risk, as well as trends from complaints feed into clinical audit anyway through our Clinical Effectiveness meetings. These contribute to us deciding what local audit to implement, but need to remain as separate entities, avoiding confusion for Trust staff and not detracting from the vital roles they currently perform.
Q7	Do you agree this would be helpful?	Yes. However this is not new. My current and previous Trust provide leadership training for relevant grades already. In addition to this audit staff often undertake further education personally, such as Masters in healthcare related studies, in order to improve their knowledge and further their careers / leadership.
Q8	Do you agree this would be helpful?	Yes, providing we are not forced into mandatory sharing procedures that are time consuming and detract from the work currently undertaken.
Q9	What is your view of each component in the proposal?	1. Recognition and acceptance of four fundamental issues: This is not new here, or at my previous Trust. We already consider these areas in order to carry out good audit 2. Development of Quality Departments (or Facilities) in Trusts I do not agree with this merging of areas. These areas need to interact so that trends from risks or complaints etc stimulate audits, but forming a Quality Department would be detrimental in my opinion. 3. Training opportunities This is not new here, or at my previous Trust. Where there is funding available for training this will happen anyway regardless of rebranding people into a Quality Department 4. Establishment of multi-Trust initiatives This element of more linking between Trusts seems like a good idea, provided that we do not end up with lists of Regional priorities on top on the National priorities we already have. 5. National clinical audit suppliers

		This is oddly worded. I agree with the idea that National Clinical Audits need to speed up their analysis and consequently feedback times, but not in increasing the number of National Clinical Audits, which for Acute Trusts is already extremely difficult to manage.
Q10	Do you have suggestions for other components?	Having now gone through this proposal in detail I am quite disappointed and concerned. I hope that the opinions received are considered. This appears to be a reiteration of what already happens at most Trusts, but with a rebranding package attached. Merging smaller areas into one larger Quality Department will not solve anything other than reducing further already depleted numbers of staff and increasing the burden placed on those remaining. I agree that risk and complaints, along with other areas, need to link with clinical audit, but this is what stimulates what local audits we perform. The results of audit would be shared with those people with an interest anyway in order to decide on the actions required. Did those who drew up this proposal really take into account how Trusts operate as there is so little here that is actually different from the current process? It is frustrating at conferences when those high up the ladder discuss what is needed yet clearly demonstrate a lack of understanding about what actually happens on the 'shop floor'. This proposal appears no different. It represents an enforced change for the worse as I see it, and will be another nail in the coffin of local clinical audit leading to real improvement in patient outcomes and care.