		points made in this document. And for Clinical Audit Staff to lose the one thing that justifies their work – a stake in improvement.
Q5	Do you agree this would be helpful?	Yes – National Audits must be very locally responsive and reflect the myriad ways services are now organised (or more cynically fragmented) before they will be able to facilitate local quality improvement.
Q6	Do you agree this would be helpful?	Yes • Especially the first and second bullet points! • 3rd bullet point – Include Improvement Departments, Patient Experience Teams and Research Teams in this? • 4th & 5th bullet point - Keep each strand of activity distinct within the proposed quality departments – don't let the distinct advantages of multidisciplinary "quality" teams be swamped by some sort of cut-price low skilled do-it-all quality drudge! • Last bullet point – can this be a criteria for judging national audits – that each should take note of and relate to care pathways as a whole even if they focus on just part – including the registries? That will help them be more relevant locally.
Q7	Do you agree this would be helpful?	Yes – there needs to be a "quality" career path from the lowly data clerk to the board, which includes clinical audit.
Q8	Do you agree this would be helpful?	Yes - we should be comparing ourselves with research staff more and making explicit the similarities between the disciplines.
Q9	What is your view of each component in the proposal?	Bullet point one - While the real issue is about making improvement happen on the basis of clinical audit data collection, your separation of the two threatens to demoralise clinical audit staff.
Q10	Do you have suggestions for other components?	Essentially you can sum up your paper as "What we need is a tighter partnership between local clinical managers and Clinical Audit staff to ensure that improvement takes place."

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?]	Yes, with the following observations - • Management etc. very concerned about "assurance" rather than improvement • National Audits display a very unfortunate "acute" bias and future funding should follow where the majority of patient activity is, not university hospital academic elitism. • The burden of data collection increasingly falling on clinical staff with poorly designed electronic clinical records systems unable to be configured for multiple data purposes – clinical, performance/financial and audit/research. The ideal should be for clinicians to enter data once only for all purposes. • However, the data skills that clinical audit staff have are from the same basic skill set required for research and service evaluation – but we often deny the overlap.
Q2	Do you agree that the current situation is not sustainable?	Yes
Q3	Do you agree with this analysis of the underlying reasons for the current situation?]	Yes – but not that the term Clinical Audit should be dropped, but it should be seen as part of a range of quality "tools".
Q4	Do you agree this would be helpful?	No – You identify the right issue here – the problem of how data collection leads to improvement and who can do what – but then you formulate it in a way that is unhelpful. Much better to see these elements as parts of a cycle rather than distinct separate activities – no point in collecting evidence if you are not committed to improvement – the real issue is who is responsible for what – managers have the responsibility for ensuring improvement and it's the link between clinical audit staff and managers that needs to be strengthened. This formulation will lead to it being weakened, and goes against the overall direction of the other