National Advisory Group for Clinical Audit & Enquiries

Consultation on Future of Audit staff in Trusts

Q1	Do you agree with this assessment of the current concerns of audit staff in Trust?	Definitely a problem with conflicting priorities, very frustrating also to have these continually change as start to doubt the value of the work we do. I work in a department which used to have a manager and 5 WTE clinical audit coordinators, now just the manager and myself (I am 0.5 WTE) for a large acute Trust (7,500 staff). Value of local audits should be questioned in terms of lack of follow-up to the audit – audit report and implementation of changes. In this small department we have put measures in place to minimise the number of audits which are lost to their departments by requiring a copy of the audit report and by requesting confirmation of action implementation. However, we also need managers and clinicians leading on audits to understand this is important.
Q2	Do you agree that the current situation is not sustainable?	It depends what is meant by sustainable. I have worked in audit for 20 years and believe that audit activity will go on, with or without the expertise of audit staff. It is more about improving on the effectiveness of audit work – ideally trusts would understand that the expertise of audit staff is worth having (& paying for) as audits would be better designed, thus producing more robust results which could be used to clearly demonstrate where change was needed. The same audit staff would also have systems in place to check whether anything was done about the audit results in terms of making changes – I believe this is valuable in itself and actually should not be diluted by audit staff trying to get involved in managing the process of change themselves. An active response from managers and lead clinicians to information from audit staff that audits were not being followed up, is also necessary.
Q3	Do you agree with this analysis of the underlying reasons for the current situation? *My responses are numbered to correspond to the outlined problems.*	1. This is not really a good excuse – if it is the case, it is an indictment of poor communication over the last 20 years – do the majority of clinicians really still believe that audit is being "done to them"? I think that many of them are happy about the idea of a clinical audit – they just feel that they lack the time to do it properly and that makes them seem negative about it. 2. It isn't necessarily unhelpful to have the role of audit staff clearly delineated – I would have a more rewarding time doing audit if that was the case, instead of being diverted to other activities, as mentioned under "Concerns". 3. Audit staff can benefit from some degree of separation as there will never be enough audit staff hours in these financially restricted times, so working too closely with clinicians can mean that it is hard to say no to requests for support which don't strictly fit in with the audit priorities. Although I find it very rewarding to work closely with individual clinicians in order to improve their understanding of an audit project or overall audit process (eg completing their specialty's audit plan) - as this tends to improve their enthusiasm - there aren't enough hours to do this for all the staff who would benefit from it. 4. Again, due to financial & time constraints, it is not easy to meet up with other audit staff. I used to do this in my first few years of working in audit but not now. It is possible that the amount of time it takes to travel to a meeting and mix with others isn't necessarily cost-effective – at least it might be hard to prove. However, if meetings focused on very specific areas and all shared their way of doing something – eg monitoring of NICE guidance compliance, then some trusts could well benefit if it resulted in a more effective process. 5. This is a huge area to address and seems to be covered in 2 different ways in this consultation. In this section, I agree with the theory that audit staff will feel frustrated if they work on an audit project which clearly highlights problems and then realise that nothing is being done. In practise, they have usually moved onto the next project working with a different department and may not realise for a while that nothing has been done. I think the primary focus of audit staff should be ensuring audits are extremely robustly designed and that clinical departments are followed up until they have produced an audit report and action plan as a minimum. It is certainly a problem for a trust if there is insufficient understanding, skill and experience to improve quality among managers and lead clinicians but this should not be the responsibility of a clinical audit department.
Q4	Do you agree this would be helpful?	I think these two key components (assessment & improvement) are already self-evident. I can't speak for national clinical audit suppliers but, as mentioned in Q3(5) above, I believe that trust audit staff should focus on ensuring audits are extremely robustly designed, in order to produce unambiguous results which can be acted on. There is also an important role in overseeing audit plans – checking they include mandatory national audits and other potentially valuable audits – and in following up clinical auditors until they have produced an audit report and action plan as a minimum – ideally until some evidence of audit implementation is received. If audit staff have to start overseeing quality improvement as well – without a large growth in the numbers of audit staff, this will be detrimental to the quality assessment activity.

Q5	Do you agree this would be helpful?	I'm not sure what is being said here but it sounds like a gentle chastisement of audit staff who moan about national audits because they don't understand them – this could be the case but presumably there is an onus on those running the national audits to provide enough information so that the reasons for collecting the data are understood.
Q6	Do you agree this would be helpful?	(i) If data collection for quality assessment could be integrated with the data needs of clinical care, of course this would be helpful but how realistic is this? Even if the data that is needed for an audit exactly corresponds to what is collected clinically on paper, it still needs to be collected on a different form for an audit – either via a paper copy or input directly electronically. This would partly be to ensure the data is not patient identifiable when collated. If the clinical data is electronic anyway, this obviously makes it much quicker to take the sub-set needed for an audit. Patient & staff surveys etc would still need to be an extra data collection exercise. (ii) Clinicians, managers and audit staff should be integrated for a specific project and their respective roles should be clarified at the outset, I do think this clarity is currently lacking. In my experience, some clinicians may still think that audit staff are there to collect the data for them but with such a small team in this trust, it is soon explained to them that this is not possible. Most local audits take place away from the scrutiny of the audit staff as we simply do not have the time to check their data collection strategy, assist with writing up the report and attend audit meetings where they will be presented to ensure that some audit actions are recorded (this was done in the past with the larger team). It has always been recognised that "greater engagement of clinicians will help establish the prestige and status of quality assessment and improvement" – the issue is how this is to be achieved. (iii) I do not think the suggested change in Organisational Structure would make a difference – i.e. just combining those different aspects of quality would not in itself mean that a "Quality Department" would be better integrated and therefore more effective than a clinical audit (or clinical effectiveness, as we are called) department. In this trust, there are senior clinicians involved in the clinical effectiveness steering group who have a positive impact in some key areas / national projects but they cannot spread themselves too thin, to get involved in every local audit. We have gone some way to ensuring involvement of lead clinicians and managers for local audit by making it mandatory to have their signatures on audit proposal forms (and no audit should be done in the Trust unless it has been registered by means of the audit proposal form). This at least indicates that they are aware of the audit and theoretically will support any actions that arise from it. The reality may be that the audit results do not get effectively disseminated and the department clinical and management leads do not sit down to agree an action plan and oversee the implementation. This also applies to acting on the results of national audit as I believe that it is very important for any trust / department to understand how the findings translate into agreed local actions so that there is full engagement. (iv) Funding: this sounds like a cunning plan to completely dismantle audit departments and lose audit staff expertise – hidden in the centre of this consultation document! (v) Focus: this seems self-evident although I expect in practice that clinicians identifying what they see as a problem with the portering service need to understand that they should approach the service tactfully, with suggestions for change. In this audit department, we have always stressed the importance of involving all groups of staff who may be impacted by the findings of an audit, in the original audit design. The problem is that increasingly we are not asked for advice as we have had to cut down on help with local audits. (vi) Clinical care: not sure what is meant by this section, it is rather woolly. As far as patients are concerned, they are not going to worry about how improvements are achieved, only that it happens.
Q7	Do you agree this would be helpful?	Two aspects to this – the clinical audit staff and the other healthcare professionals / managers. Clinical audit – "Enhancements in the roles and responsibilities of audit staff" will mean higher bandings and higher costs which is unlikely to happen in the current climate, or if it does happen, will mean even less staff are employed. I agree with the list of existing technical knowledge but if a new role is also to encompass behavioural skills, then there will be less time to do the audit work. It is also not such a new idea as many years ago, I attended a workshop on managing change after audit and I believe it is still part of clinical audit professional training. In reality, time constraints on the role mean that more time spent facilitating the change as well as advising on / carrying out the audit will mean less audits. I personally did not actually get involved with the facilitation of change after the training although theoretically, it is part of the role. (The fact that some would say it is better for audit

		staff to ensure that less audits are done if they are better designed and seen through to the facilitation of change, is another argument). "Knowledge of national policy developments" I would see as part of a manager's role – with the aim of ensuring that the audit staff understand how their role fits in with those. Other professionals – this section in the consultation is a bit vague but I would definitely agree that clinicians are still not being taught enough about audit – evidence of this can be seen in some of the audit proposal forms we receive, eg the simple lack of awareness over the need to audit against standards is very disappointing.
Q8	Do you agree this would be helpful?	There can be no argument about learning from the best and increasing opportunities to do so sounds like a great idea but the time that is spent doing that has to come from somewhere and what group of staff in any trust has spare time? This would be an excellent topic for a research study, ie how to calculate when it is advantageous to use your time to visit other trusts and learn how they do things, compared to carrying on with the way you do things now. In my own opinion, I have always thought that unless you are comparing your own work practices to a very similar set-up, then it is not likely to be practical to spend time in another department as there will be too many variations (I realise this is quite a pessimistic view). A simpler approach might be to have a national website where any trust who believes they have an excellent approach to a particular area, can post that information there. The information can be posted under different categories, to make it easier to search. Obviously this would have to be hosted and would be a cost to whichever organisation did it. I am thinking about broader processes (eg we believe in this trust we have a good system for monitoring NICE guidance compliance) rather than individual audits which may be too specific to be relevant elsewhere. Some of this is already done when submitting ideas for conferences / awards but the advantage would be to have all these ideas stored in one place. There could also be a forum for comments from those who try the ideas.
Q9	What is your view of each component in the proposal?	Comp. 1 : These all sound like statements that are most likely already accepted but how will this be measured? Comp. 2 : For my trust (and I would have thought for others), I do not see this as a significant change from the way our department is run, in fact I see it as a disadvantage to have a more "woolly" title. When I started in this job, we were the clinical audit department and I think it was a mistake to be re-named as the clinical effectiveness department as so many people are not sure about what we do. We already look to "provide specialist advice, facilitate activities and guide quality assessment and improvement." On the whole, we do not "undertake the tasks themselves as that is not feasible given the limited capacity of such departments" so this does not represent a change. Comp. 3 : I agree there could be some improvement in the way information about national and local policies affecting the quality agenda is disseminated. My comments in answer to Q7 illustrate that I have my doubts about combining the role of audit expertise and behavioural skills in quality improvement. If this does go ahead, I think it would be likely to cause even more disparity in the banding of clinical audit jobs and would decrease the number of jobs. Comp. 4 : This sounds desirable if resources allow. Comp. 5 : This should result in improvement in the way national audit findings are used locally.
Q10	Do you have suggestions for other components	Component on embedding the carrying out of good quality clinical audit in doctors' (and other healthcare professionals) progression / appraisal. Some years ago we were encouraged to hear that doctors in training had to provide evidence of audit involvement, in order to progress. We found it difficult to ascertain how this was going to work, eg what counted as evidence, and I see it as a missed opportunity to ensure the messages about what counts as an audit – and how it should be seen through to the end – are emphasised. I think that Foundation doctors end up with mini projects that fit the time they have, rather than being taken from the Trust's priorities, there is also a lack of follow-up because those doctors have moved on. In these cases, the audits should always be overseen by a permanent member of staff and that lead should have to feedback to the junior doctors what happened 6 months to a year after the audit was finished, so they can see the bigger picture. I also believed that as an audit department, we would be asked to give evidence of consultants' audit activity, to feed in to their appraisal. To my knowledge, this happened only once and again I think it is a missed opportunity to educate consultants over what can be counted as an audit and the importance of completing the audit cycle.