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?	Agree to points 2,3,4,5, 6a Disagree with point 6b and conclusion.
		1. Disagree - Too many demands from numerous sources with a lack of clarity as to which are mandatory and how to determine priorities.
		2. Agree - Insufficient resources and skills
		3. Agree - Insufficient support from management, senior executives and Trust Boards exhibited through points noted.
		4. Agree - Value of some audits questioned
		5. Agree - Insufficient ownership and engagement by clinicians
		6a. Agree - Diverted to undertake other activities - supporting risk management, compliance, safety and other more immediate concerns.
		6b. Disagree - Diverted to undertake other activities - supporting clinicians' research and undertaking administrative tasks
		Disagree conclusion - Audit staff in Trusts perceive that the consequences of these challenges is that the balance of their work (and the use of available resources) has shifted to too great an emphasis on data collection. This risks deprofessionalising audit staff and undermining their status in the eyes of other Trust staff.
Q2.	Do you agree that the current situation is not sustainable?	Yes, SCH has experienced loss of staff through people leaving and posts are not being replaced. Post holder work load delegated to other members of staff.
Q3.	Do you agree with this analysis of the underlying reasons for the current situation	Generally agree, See below comments.
	Point 1 - Understanding of what 'clinical audit' is varies: the term may be more of a hindrance than a help.	Disagree, however there are concerns with the cultural perception and the inclusion of other discipline not just clinical staff. It is not unattractive when there is time for it to be completed.
	Point 2 - Multiplicity of approaches to improving quality is not sufficiently appreciated.	Partially disagree, as there is no perception that national clinical audits are undertaken solely for use at a local level within the trust. However we do agree with the initial statement 'Multiplicity of approaches to improving quality is not sufficiently appreciated'. (Would appreciate a section on National clinical Audits in its entirety and not be slotted into multiplicity of approaches)
	Point 3 - Concept of and Audit department creates unhelpful boundaries	Agree, • It is the clinicians doing the audit but with support of the audit department. • The location of the department is a primary boundary.
	Point 4 - Isolation of audit staff in individual Trusts: risks reinventing the wheel.	Partial agree that tools are shared, there is networking and conferences. But this could be difficult to achieve due to internal processes and intellectual property rights. It would be beneficial but is it viable?
	Point 5 - Quality improvement skills and knowledge of clinicians and mangers poorly developed.	Agree, in line with quality account and is now built in following Darzil.
Q4.	A new vision of audit staff in Trusts. Do you agree this would be helpful?	Partialy only - would agree that it could be helpful - many of the points are already in place such as the Quality assessment and Quality improvement bullet points.
Q5.	Recognition in trusts if multiple approaches to quality improvement. Do you agree this would be helpful?	Agree, as most of these points are already practice within the trust. The comment that staff may look at it as 'just collecting data' and will not seen as essential has been overcome and is recognised as a method to quality improvement and there is evidence of this. The issue is obtaining the finance for it.
Q6.	Greater integration: 'quality is everybody's business'. Do you agree this would be helpful?	Yes, see below comments.
	• Data collection for quality assessment	Agree and do so already
	• Clinicians, managers and audit staff.	Agree and partially do so already
	• Organisational structure	Agree are isolated
	• Funding	Agree should be included with under one budget for all quality improvement.
	• Focus	Agree a structured audit for each.
	• Clinical Care	Agree there should be patient perspective in service design.
Q7.	Supporting enhancements in the roles and responsibilities of audit staff. Do you agree this would be helpful?	Agree it would be helpful.
Q8.	Sharing experiences and learning form the best. Do you agree this would be helpful?	Agree, best practice is important however with time being restricted this may be difficult to do. Conferences previously have been a method of doing this
Q9.	What is your view of each component in the proposal?	
	Point 1 - Recognition & acceptance of four fundamental issues	
	•The advantage of distinguishing the two key aspects of achieving high quality services: quality assessment and quality improvement	Agree and we already do

	•The complementary assessment and quality improvement	Agree.
	•That quality is the collective responsibility of clinicians, managers and audit staff	Partially Agree, as it should include directors too.
	•That clinicians and managers must accept that they are responsible for assessing and improving the quality of the clinical service they run.	Agree.
	Point 2 - Development of Quality Departments	Agree, Access to the trust board via and executive Board member is important.
	Point 3 - Training Opportunities	Agree, there is access to training opportunities.
	Point 4 - Establishment of Multi-Trust initiatives	Agree, there is data available which could be used to give regional overviews.
	Point 5 - National Clinical audit suppliers	Agree, however there should also be reference to the timeliness of the National Clinical audit suppliers feedback.
Q10.	Do you have suggestions for other components	For a programme to be developed which allows the Clinical Audit department to approve and sign off Junior doctor audits in collaboration with their supervisors.