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/

<table>
<tr><td>Q1</td><td>Do you agree with this assessment of the current concerns of audit staff in Trust?]</td><td>Some additions need to be made, including:
1. Reference to the role of audit staff/teams in contributing to the transition to an outcomes-based culture in the NHS, and integration with performance teams.
2. Great concern exists about the quality and value of national audits, which need explicitly to address national priorities as set out in the NHS Outcomes Framework, national CQUINs, NICE Quality Standards and NHSLA standards.
3. Ownership/engagement of clinicians – financial austerity in the NHS has greatly increased the pressure on clinicians to increase clinical income-generating work, reducing time for clinical audit and other QI activities.
4. The complete removal of most primary care audit teams at a time when it is more important than ever to be assessing patient outcomes and clinical quality across the entire patient pathway.
5. Confirmation that insufficient resources and skills refers to staff at all levels of seniority.</td></tr>
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<tr><td>Q2</td><td>Do you agree that the current situation is not sustainable?</td><td>We agree that it needs to change. The following would be helpful:
1. Integration of ‘best practice recommendations’ at a national level. Assessing and integrating the recommendations from NICE, confidential enquiries and national audits is an enormous knowledge management task being repeated in every clinical audit/effectiveness department across the country. It would be far more cost-effective and efficient to do this centrally.
2. Resources and skills within</td></tr>
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		audit/effectiveness teams is variable – but this is a local issue for Trusts to resolve. A nationally-recognised qualification would be very helpful, however. 3. Value of national audits is extremely variable. They must link explicitly to NICE Quality Standards and/or CQUINs and/or NHSLA requirements. Time must be allowed in the national audit cycles to enable improvements (annual data collection is often too frequent). With clinical audit embedded in requirements by commissioners (through standard contract [NCAPOP programme] and CQUINs), Monitor/DH (through the Quality Account), NHSLA assessment standards and CQC standards, we believe a great deal is being done externally to achieve support from 'management, senior executives and Trust Boards'.
Q3	Do you agree with this analysis of the underlying reasons for the current situation?]	This section does not really reflect the experience of our organisation. There is a need to evolve and integrate quality improvement (and performance monitoring) activities – we don't really see this as an 'underlying problem', more of an exciting opportunity. Trusts do need experts in both information analysis skills and improvement skills – sometimes audit staff are called on to be both but perhaps a better model would be to separate these into different staff members or even different, but closely allied, teams (like the modernisation teams). We believe that that the definition of clinical audit, first by NICE (2002) and more recently HQIP (2011) is clear. A definition of clinical audit is necessary to help clarify the distinctions between clinical audit, research, service evaluation and other quality improvement tools. The definition should be used to underpin a Trust's Clinical Audit Strategy which is the basis for embedding clinical audit within the organisation.
Q4	Do you agree this would be helpful?	Yes – but comment as above. Perhaps both these roles don't need to be undertaken by an 'audit department' The definition being proposed does not substantially differ to that already used by NICE (2002) or HQIP (2011) i.e. the measurement of

		patient care and outcome against agreed standards of best practice to drive improvements in the quality of care provided. The role of suppliers of national audit is already outlined in the HQIP document Principles of Quality in National Clinical Audit. This set of best practice standards should be applied to all national audits reportable via the Quality Account in order to standardise quality.
Q5	Do you agree this would be helpful?	ditto
Q6	Do you agree this would be helpful?	We don't believe this will necessarily best be achieved by a prescriptive organisational structure as this continues the artificial boundaries, albeit slightly wider ones. Clinical quality improvement needs to be seen as mainstream – the everyday work of the clinical teams and Divisions and not an activity that is separate to good clinical care and management. In particular, it needs to be embedded into operational and performance management. We believe that matrix working is the key, not only between effectiveness, patient experience and safety, but also with performance teams, strategy teams, data management teams, EPR teams, 'change leaders/modernisation' teams, education, research, operations, contracts, finance etc. Matrix working can be facilitated by Trusts having a clear vision that focuses on improving patient outcomes, to ensure all the support teams, clinical teams and Divisional management teams are pulling in the same direction. It doesn't need a new type of department to be established, as it is unlikely that there would be one model that would work well in every type of Trust. The focus needs to be on developing a robust vision and strategy for quality improvement at national and local levels, of which clinical audit is a part. It would be helpful if this were explicitly structured clinical effectiveness, experience and safety, so that it supported the national NHS Outcomes Framework.
Q7	Do you agree this would be helpful?	Very helpful, especially if there are flexible options in delivery. Although funding will be challenging

		(see below).
Q8	Do you agree this would be helpful?	Yes.
Q9	What is your view of each component in the proposal?	1. Good – but add 'all NHS staff' into bullet 3. 2. Not comfortable with this – too prescriptive. Would be happier with 'quality improvement function'. Needs greater emphasis on patient outcomes. 3. Perhaps this could be stronger – a formal qualification or accreditation for staff/departments - ? The training budget within existing clinical audit departments has been eroded as part of wider cost savings. This will significantly impact a Trusts ability to deliver on this standard. How will this standard be applied – training workshops available via HQIP or will the onus fall on the local Trusts to provide the suggested training? 4. Some reservations about 'quality departments' but agree re: the value of contribution of those with expertise in improvement. 5. Strongly agree. There needs to be explicit minimum standards for national audits.
Q10	Do you have suggestions for other components?	**Overall comments:** We would like to see the evidence-base for the statements in this paper (there are no references) and to be reassured that a thorough review of the evidence has been undertaken. There is research on what makes improvement/quality initiatives most likely to be successful – this needs to be summarised and included. The paper refers to changes in the 'quality landscape' and that these provide 'wonderful opportunities' but doesn't set out what these changes are or what the opportunities are (or threats). A vision of how clinical audit supports national strategy would be a very helpful start to the paper.