# 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/

**Please note:- This response is based on the experience of clinical audit staff in our organisation which will be different to that experienced by staff elsewhere within the NHS**

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| Q1 | Do you agree with this assessment of the current concerns of audit staff in Trust?] | From our perspective, we partly agree and are responding to each demand individually.<br><br>*Insufficient resources and skills*<br><br>We agree that insufficient resources and skills is an issue and that clinical audit is seen as an easy target.<br><br>*Insufficient support*<br><br>We partly agree. It is not finance taking greater priority over quality (although obviously the tension is there) which is our problem as such. The issue from a clinical audit perspective is that there is more interest in 'true' quality assurance over clinical audit. As a registered pharmaceutical manufacturer, a Quality Management System is required by law and this system greatly overshadows clinical audit. This issue is more akin to a focus on mandatory / statutory activities related to that QMS and a focus on risk management and safety targets. This is changing though as a result of recent work from both parties to work collaboratively and we would like our hard work in changing this to continue.<br><br>*Value of audits questioned*<br><br>We partly agree and do have some of our local (organisational) audits are questioned. We do not partake in national audits but sympathise with the views of colleagues in Trusts about the value of poor quality, poorly managed national audits. We feel that this is the biggest issue.<br><br>*Insufficient ownership / engagement* |

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| | | We agree. True Quality Assurance activities can reinforce the view of audit being a box ticking exercise, however we are working on this with some degree of success. We feel that revalidation will help to change this perception further.<br><br>*Diverted to undertake other activities*<br><br>We partly agree. We are asked to support some research given our clinical audit skills are similar to those that are needed for certain elements of research. We do support this but place it behind all clinical audit work in priority.<br><br>*Shift of emphasis to data collection*<br><br>We disagree with this. Our experience does not reflect this being a concern. |
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| Q2 | Do you agree that the current situation is not sustainable? | We wish to express our concern that this is not a well-worded question and could be seen as leading. We also feel that the document as a whole is written in a way that suggests that these are not proposals for discussion but advance warning of the proposals being a fait accomplis. Given the importance of the topic, we feel that this is disappointing.<br><br>It is difficult for us to answer this question. We feel that our current situation combined with current resources is sustainable and therefore disagree. We feel that a number of initiatives could / will have an impact on the situation such as revalidation, greater involvement / understanding of NEDs etc.<br><br>However, organisational change as most NHS organisations are currently going through will always make clinical audit more difficult. To a certain extent, we feel that the current situation is distorting the picture and that once new structures are embedded, things may be different. |
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| Q3 | Do you agree with this analysis of the underlying reasons for the current situation?] | From our perspective, we disagree and are responding to each problem individually.<br><br>*Understanding of clinical audit*<br><br>We disagree with this as a problem underlying those previous concerns. We acknowledge that there is confusion at times but there has been a lot of work over the years to reinforce what |

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| | | clinical audit is about and that should be continued rather than discarded.<br><br>Understanding of clinical audit varies but we are of the opinion that it is quality improvement that is not well understood. We feel that most clinical audit staff are clear and understand the relationship and that this is more an issue with non-clinical staff. We also feel that some press coverage that does not state that clinical audit is the source of many of the reports on current state of care is unhelpful.<br><br>We actually feel that changing the name of clinical audit at this point would be more of a hindrance than a help and create much more confusion than there currently is. We feel that changing the name will have little or no impact on the view that clinical audit is unclear, unattractive or unwelcome and will not solve the issue. We feel that the interpretation / understanding of clinical audit is what should be tackled rather than changing the name.<br><br>The suggestion that clinical audit is unwelcome as there are connotations of checking and policing clinical activity is a poor description – we feel that 'unwelcome' is a poor choice of word. It is only unwelcome by those that don't understand the focus of clinical audit.<br><br>Work undertaken in the last few years by HQIP and us on the back of that, has helped to dismiss uncertainty and inconsistency in the view of the role of audit staff. Much work has been put in to correcting this which has the potential to be wasted.<br><br>*Multiplicity of approaches*<br><br>We feel that the issue is more around communication and collaboration between different staff involved in quality improvement activities. This includes local audit staff and those who run national clinical audits. We feel that there is a role for clinical audit staff in creating recommendations / implementing change etc resulting from the outcomes of national clinical audits – however, in many places this is not seen or understood and Trusts see their role in national clinical audit purely as data collectors. Part of this problem is the unacceptable turnaround times for national audits. |

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| | | *Concept of an audit department*<br><br>We disagree that this creates unhelpful boundaries as we feel that it actually allows for an element of objectivity and independence and helps create a set identity. From our perspective, this again revolves around communication and relationship building with senior management. We feel that distinct audit department structures can have benefits that outweigh the negatives such as impartiality, less opportunities for staff to be pulled in to directorates to do other work, less pressure to 'skew' audit results.<br><br>We feel that revalidation will help bring audit staff and clinical staff closer together.<br><br>*Isolation of audit staff*<br><br>We do not entirely understand the issue described. However, we do feel that there is a greater need for cross-working across organisations including clinical audits spanning multiple organisations. We also feel that improved clinical audit networks would help, as long as the correct people attend those networks. Allocation of time and resources to attend network meetings is vital.<br><br>*Poorly developed QI skills and knowledge*<br><br>We agree, although changes to clinical audit in isolation from other QI activities will not help this. We feel that this is a wider issue and that QI activities suffer from not being vital parts of job descriptions of relevant staff. |
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| Q4 | Do you agree this would be helpful? | We were confused by this section and found it difficult to discuss in parts. We feel that some things would be helpful whilst others would not.<br><br>We again feel that this reads as a fait accomplis as the document states that this suggestion is shown to work but provides no references to the evidence. We would like to see the evidence that this element is based on<br><br>We feel that splitting clinical audit in to the two distinct activities described risks devaluing the profession and reinforcing the notion of clinical audit being data collection with nothing on the end. We also feel that 'quality assessment' is different to quality assurance and that this document takes a very simplistic view of true |

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| | | quality assurance when actually it reflects a system of which one component can be assessment (but not always). Quality assessment and true quality assurance are not the same thing. This needs to be acknowledged before any decisions are made.<br><br>We feel that the distinction between the two activities would create very unhelpful boundaries and within our organisation in particular would damage clinical audit. This would also apply to most scientific communities where quality assurance exists as an entity different from the definition in this document.<br><br>If anything, we feel that the definition of clinical audit should be changed to encompass these two aspects and that clinical audit should remain as the umbrella term for those two approaches. Rather than redefining clinical audit to become quality assessment and quality improvement, quality assessment and quality improvement need to become the definition of clinical audit.<br><br>We also feel that there is a lack of understanding of the relationship between national and local clinical audit – the poor quality of national clinical audit has meant that local clinical audit staff do not understand that part of their role should be to develop actions and recommendations on the back of national clinical audit results. However, this is not surprising when it can take up to two years to publish audit results which then gives rise to the classic response of 'well things have changed since then' when trying to implement required change. Technology must be used to improve the turnaround of national clinical audits. |
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| Q5 | Do you agree this would be helpful? | Although we don't fully understand this section, we agree that this would be helpful, except for the distinction of clinical audit in to quality assessment and quality improvement.<br><br>It is disappointing that this appears in parts to be a sales pitch for national clinical audit without recognising the deficiencies currently in place in that system.<br><br>We feel that this 'issue' could be partly overcome through national clinical audit suppliers / providers giving greater clarity over why they are collecting the data that they are |

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| | | asking for and by them improving their processes |
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| Q6 | Do you agree this would be helpful? | Although we agree with most points (although we would like to use the term clinical audit over quality assessment or quality improvement), we disagree with establishing Quality Departments as a blanket approach. Although some organisations may benefit from such creation, this would simply blur the boundaries within our organisation, between a true Quality Assurance function and clinical audit – senior management would see it as duplication, it would do nothing to aid our quest to 'sell' and improve clinical audit and would likely result in the demise of clinical audit within the organisation. Again, this would likely be the case in other organisations with a large scientific community.<br><br>We do not see any advantage of aligning clinical audit funding with other funding – this would increase the probability that clinical audit funds would be used for other activities. In terms of focus, we feel that the term 'service audit' adequately reflects what clinical audit teams should be doing – improving the services provided through auditing clinical and non-clinical aspects of services that will improve the services offered to patients. |
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| Q7 | Do you agree this would be helpful? | We agree with this and have no problem with clinical audit staff expanding their knowledge around quality methods and understanding. |
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| Q8 | Do you agree this would be helpful? | We agree that this would be helpful and any opportunities to share good practice should be encouraged and promoted. |
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| Q9 | What is your view of each component in the proposal? | 1) We recognise and accept the last 3 bullets as fundamental issues and as being beneficial. However we do not feel that the first bullet point is the fundamental issue that it has been described as (see earlier comments)<br><br>2) We do not accept this as a required change (see earlier comments) as this risks clinical audit being diluted and swallowed up by other quality approaches. We do however, see no reason why this could not be the definition of an audit department or a clinical audit facility within NHS organisations.<br><br>3) We completely agree with these as issues and feel that this would improve the impact of |

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| | | clinical audit staff (not Quality Department staff – another example of how we feel that some issues are a fait accomplis)<br><br>4) We would encourage any multi-organisation initiatives<br><br>5) We agree with this and would add that national clinical audit suppliers also need to investigate how they can improve their service, particularly now that they receive money from Trusts to undertake the audits that they manage. |
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| Q10 | Do you have suggestions for other components? | We feel that the future direction of the NHS in England will make it difficult to ensure that views from different types of organisations carry equal importance. However, we do feel that it is important that any decisions emanating from this consultation are made with those differences in mind and not based on one sector of one overall organisation. |