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?]	Partially. Disagree with the following: • perception of the knowledge and skills of staff being insufficient. Members of our department have long standing skills developed in response to the initiative in 1994 when the NHS training directorate rolled out "Getting ahead with clinical audit" Under this they were trained to facilitate quality improvement but this has not been aligned with the management knowledge and resource to support this. • We do not agree that there has been a "diverting" to such activities as support for risk management, compliance etc.Audit has a vital role to play in assurance of compliance with alerts, action implemented after serious incidents etc. Agree on the following points: • there are too many demands with a lack of clarity over which are priorities from the pressured business unit managers that we support. • Inadequate resources in the clinical audit departments to meet all the drivers for undertaking audits. From our perspective, the basic issue is that the clinical teams with targets to meet and managerial responsibilities now inbuilt to their roles do not have the time and space to "close the loop" on clinical audits leading to low job satisfaction for clinical audit staff. A common grievance is that "no one ever gets back to us despite constant chasing".
Q2	Do you agree that the current situation is not sustainable?	Yes. Clinical audit is an important process for assurance and must fulfil its original purpose which was to improve care for patients.
Q3	Do you agree with this analysis of the underlying	Strongly disagree with the notion that there is a lack of understanding about what clinical audit

	reasons for the current situation?]	is. The pioneers of clinical audit succeeded in disseminating its purpose and the methodology. It is one of many quality improvement tools. What may have happened in some places over time is that lack of clinical audit professionals means that sub optimal practice took place and resultant “audits” have not met the needs of the organisation. Disagree that an ”audit department creates boundaries”. If audit staff are subsumed in business units there is the risk mentioned before of being diverted into other activities. Agree with the multiplicity of approaches to improving quality and that the quality improvement knowledge of clinicians and managers is poorly developed.
Q4	Do you agree this would be helpful?	Yes – can identify with the Quality assessment / quality improvement activities. But the national audits recommendations need to be aligned with Commissioners priorities.
Q5	Do you agree this would be helpful?	Yes. We already have appreciation of the role that our local trust data contributes to the national picture of service provision.
Q6	Do you agree this would be helpful?	Partially agree, as we disagree with the points in the paper and don’t recognise the paper’s interpretation of the roles of the clinical staff and audit staff interaction. We have always worked to a model where the clinical audit staff had a “patch” responsibility and were deferred to for audit matters. Can see the benefits of a “Quality facility” and could be what we have locally in the form of a Delivery Support Unit.
Q7	Do you agree this would be helpful?	Agree, but to take on these additional responsibilities will require additional staff and draw on several professional groups..
Q8	Do you agree this would be helpful?	Yes. We would support building networks and sharing with other organisations.
Q9	What is your view of each component in the proposal?	1. Agree with all points. 2. Agree – would support the development of quality departments. Currently locally clinical audit is part of governance and quality and safety. 3. Agree – management of change would be a key focus for training. 4. Agree and support – aligns with our introduction of Quality Improvement Fellows

		(QIF). 5. Agree – it is too difficult to get hold of the reports of local performance in national audits and they do not leave enough time for quality improvement to be implemented before the data collection starts all over again.
Q10	Do you have suggestions for other components?	Support the culture of clinical audit and reinstate the respect for its role in quality improvement through the medical training/ Deanery links. Currently there appears to be a line being spun that clinical audit doesn't matter as other quality improvement / service reviews are the favoured way – this needs to stop.