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?]	Too many demands: Yes Lack of clarity on which are mandatory: No Locally determined as national audits required for Quality accounts and NCAPOP. Previously it has been difficult to work out which national audits are mandatory, however HQIP have improved the central collation of information about the audits so it is becoming clearer. How to determine priorities: No In addition to the mandatory audits, audits required for NHSLA and CQC, CQUIN topics, other national audits deemed a priority for the trust and those required to meet key risks are prioritised as the core audit programme. There are some local concerns that the trust priorities don't include/match the trust clinicians' deemed priorities but there are plans to improve/address these concerns. Insufficient resources: No The clinical audit team has been adequately resourced in this trust. Insufficient knowledge skills: No The range of skills within CA team is considered good (over 30 years experience within the team). The team are generally well respected within the trust. Limited understanding of wider policies: No Considered quite good, no barriers. From April 2012 team re-integrated with the Quality and Standards team which provides better engagement with what is going on in the rest of the trust and outside. Insufficient support from management: No CA team now have links via the Head of Safety & Risk to the Director of Nursing and Quality. They have been represented at management meetings and therefore do not feel unsupported. Annual and quarterly reports go to divisional and management meetings. Value of some audits questioned - local: No Audits are valued, but aren't always followed through to improvement/re-audit as well as they could be. Value of National audits questioned: Yes Only a small number are relevant to us as a specialist trust. They are seen as a priority but

		design and execution are seen as suspect in many cases. As a tertiary treatment centre we don't always get the benefit of them – ie not always able to access the data, not recognised in the annual report (all data attributed to referring trusts). Some evidence of improving situation. Insufficient ownership and engagement: No Very good engagement in general. Where occasionally a problem it is in projects that may be perceived as 'top-down' which can include national audits. Diverted to undertake other activities: No Very rarely a problem at this trust. Too great an emphasis on data collection: No Not the case for us; healthcare professionals still undertake vast majority of data collection. When CA team involved, it is mainly to support the clinician. Current situation unsatisfactory & not sustainable: No Not for our trust.
Q2	Do you agree that the current situation is not sustainable?	If the situation is as you describe then trusts will find it difficult to sustain, however, we do not face the majority of the concerns you detail and so our current situation in respect to clinical audit is sustainable. We do feel we have room for improvement but believe there is potential to do this internally and we are supported from the trust to do this.
Q3	Do you agree with this analysis of the underlying reasons for the current situation?]	Understanding of clinical audit term: Do not feel that the term is a hindrance. It's about education and not sure it would be clearer if called 'quality assessment and improvement'. The changing of the term would create more confusion. We agree that there is still more work to do to focus on the improvement aspect but this is done through our education and training division. Multiplicity of approaches: CA team not used as fully as could be in other types of quality improvement initiatives – they could perhaps be better integrated, for example Unhelpful boundaries: Not within our trust; we're seen as part of the team Isolation of audit staff in trusts: We fully participate in local networks but do agree that more sharing of such things as the audit tools and project methodologies would be helpful. QI skills and knowledge of clinicians and managers: We have experienced some issues which point

		to a lack of skills/knowledge – but are uncertain about the extent of the problem. However, we provide training in clinical audit skills to junior doctors and permanent trust staff. In Summary: There is room for improvement in the way that QI is undertaken, but we are not sure that these reasons necessarily are the causes.
Q4	Do you agree this would be helpful?	Explicit definition and recognition of Quality assessment and Quality improvement: No Would like to use these 2 components more in training around CA but still see them as the basis of CA. Clarifying contributions: National audit suppliers: agree with statement. Audit staff: not sure how this is much of a change for us locally. In summary not sure that this will necessarily be helpful to improve our position
Q5	Do you agree this would be helpful?	Recognition of multiple approaches to QI: The CA team are quite aware of our contribution to other initiatives and that datasets often have to be large and complex. There are some very large national audit datasets which could have been better introduced incrementally as the capacity to collect the data improves (i.e. not attempting to run before they can walk).
Q6	Do you agree this would be helpful?	Quality is everybody's business: Yes, agreed Data for quality assessment should be integrated with data for clinical care: Our trust is already acting on this with initiatives to improve core dataset recording. Closer integration: This isn't the issue in this trust; we need to stimulate the improvement activities sometimes as clinicians may stall once the audit data has been reviewed and may need help with solution design to best achieve their recommendations. Organisational structure: We don't feel this is an issue at our trust. We don't feel that re-naming the department will change things necessarily: we are already within the Quality and Standards division. Funding: Very difficult to see how funding for PAs can be re-aligned and not sure that they are spending much time on audit activities. CA team request notes for audits in most cases. Foundation doctors are already collecting data for clinical audit projects. Focus: Clinical audit already involves non-clinical

		aspects of care. We have a role to involve all stakeholders and don't distinguish clinical and non-clinical roles. Clinical care: Not sure there is any issue for the patient perspective
Q7	Do you agree this would be helpful?	Supporting enhancements in CA team role: Yes; further training in QI is useful. We do need confidence to take on board a greater role in change management if this was accepted as our role. Would require trust agreement to include in the clinical audit strategy.
Q8	Do you agree this would be helpful?	Sharing experience: Yes, agree need to share. CA team not aware of the organisations mentioned; some concern that engaging with multiple organisations will be onerous and complicated for CA teams to directly benefit from. Need to develop CA team skills. Need to clarify that this is automatically the role of the CA team or whether forms part of a wider strategy for sharing.
Q9	What is your view of each component in the proposal?	Recognition and acceptance of the 4 fundamental issues: 1. Distinguishing quality assessment and QI – uncertain this is fundamental issue 2. Complimentary benefits – Yes 3. Collective responsibility: Yes 4. Responsibility for clinical services – Yes (but not aware that this isn't the case) Development of Quality departments (Facilities) in trusts: we are already under Quality and standards – may be scope for trust to draw more on skills of CA team in other QI initiatives Training opportunities: Yes, if scope of CA team to be extended. Multi-trust initiatives: always happy to engage and participate in regional and national activities but needs to be resourced National CA suppliers: Yes, this would be helpful; there are some indications that this has started.
Q10	Do you have suggestions for other components?	Reduce the number of overlapping QI initiatives. Whatever is planned needs to be simple and easy to roll out in current climate. Ensure that it is clear which elements are attributable to tertiary centres and which to referring centres in national audits