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/

Q 1	Do you agree with this assessment of the current concerns of audit staff in Trust?]	The majority of concerns highlighted by NAGCAE are an accurate reflection of the current situation. However, many of these problems have existed for years. It is great that NAGCAE want to address the situation, but most of these issues have existed since 2007 (and before) e.g. lack of senior management engagement in CA, insufficient resources, lack of ownership from clinicians, etc.
Q 2	Do you agree that the current situation is not sustainable?	Absolutely not! This is an over simplification of the current situation. The phrase 'not sustainable' is an 'over-the-top' conclusion. We would argue that local CA has been in the same situation for many years and it has continued. If nothing is done to change the direction of local audit, it will continue beyond 2013, 2014, etc. Where we agree with NAGCAE is that now is the perfect moment to examine how local clinical audit functions and address ongoing problems.
Q 3	Do you agree with this analysis of the underlying reasons for the current situation?]	Most of the points NAGCAE makes are valid. But it is disappointing that some of these issues have not already been addressed. Point 1 should have been resolved a long-time ago. NAGCAE appear to view the term 'clinical audit' as a problem. The term 'clinical audit' is the internationally known term and describes the correct methodological approach. We need to ensure the right QI tool is used and identified in order to address the relevant issue. The term 'clinical audit' is not a problem, it is how clinical audit is mis-used that needs to be addressed. Point 3 is very much an over-simplification of matters. Not

		all Trusts have audit departments and some include clinical staff and senior managers and work brilliantly. There is also little mention of the increased burden of poor quality NCAs in recent years that have impacted significantly (negatively) on local audit. The workload involved has impacted on the delivery of local clinical audit in Trusts, disillusioned audit staff (poor methods and some 'non-audits' included in the NCAPOP, extra burden of co-ordinating new NCAs and collecting data), etc.
Q 4	Do you agree this would be helpful?	This is quite an academic and technical overview from NAGCAE. We agree that audit needs to focus on (1) improving patient care and (2) assuring compliance and patient safety, etc. This needs to occur at a national and local level. However, we need to clearly define what is audit and what is not (there is clear literature on this), and we need to focus on better quality audits. NAGCAE appear to be suggesting that 're-branding' is the solution here. We believe that this is not the case and we need to focus on engagement and culture. Clinical audit works given the right stimulus. The key is to get the right stimulus in place.
Q 5	Do you agree this would be helpful?	We would agree that some 'national datasets needs to be large and complex'. However, there is no consistency in NCA methods. Some are ongoing data collections that do not allow for the opportunity to review, change and re-audit. Others collect insignificant numbers that are not representative of the local population. We agree that 'success in improving quality will come about through a combination of local and national interventions' but to date, many NCA's have been undermined by not utilizing the skills of expect local audit professionals. More crossover working is needed between local – national audit staff.
Q 6	Do you agree this would be helpful?	The points made in this section are mostly appropriate. However, the third bullet suggesting a move from 'clinical audit departments' to a 'quality department' is not correct. In the first instance, NAGCAE are

		assuming the existence of 'audit departments' in each Trust. In many cases, Trusts now have wider governance and QI teams in place and reference to 'Trust' over-simplifies the NHS landscape with the emergence of CCGs, social enterprises, etc. A good QI/audit/quality team will have successfully incorporated audit staff, senior managers and clinicians a long time ago. **This is about culture, not structure!** We have two concerns here: 1) will the emergence of 'quality departments' lower the profile of clinical audit and 2) how do NAGCAE propose they will enforce all Trusts to adopt quality departments?
Q 7	Do you agree this would be helpful?	In a nutshell this sounds encouraging. NAGCAE state 'audit staff in Trusts will require support, training in guidance'. However, how does this recommendation from NAGCAE relate to the local audit support, training and guidance provided by HQIP in the last 5 years? We agree that more focus is needed on methodological and leadership skills for audit staff. Many audit staff need wider skills in project management, team-working and change management. We would also point out that the above will require significant financial investment – where will this come from? NAGCAE appear to be 'tying themselves in knots' here. There appears to a suggestion that audit departments will become 'quality departments' and audit facilitators will be re-trained and re-branded. Page 1 of the NAGCAE document warns against 'de-professionalisation' of audit staff. Planned re-branding and less focus on the term 'clinical audit will expediate this, not prevent it from happening.
Q 8	Do you agree this would be helpful?	Capturing examples of best practice in audit (projects, methods and approaches) is an age-old problem. The NCAA tried to address this in the 1990s, HQIP have tried in the 2000s. 'My best-ever clinical audit' initiative in 2011 led to zero responses. There are pockets of success and these needs to be examined. NAGCAE are correct that local audit would benefit from

		sharing best practice. However, changing practice here will be difficult. Audit staff are rightly often possessive of their hard work, there has been problems with theft of IP in the past and increased competition across the NHS will arguably make Trusts less likely to share audit resources/ideas with others.
Q 9	What is your view of each component in the proposal?	We support much of what NAGCAE is proposing in the consultation document. This work will raise the profile of clinical audit and this consultation fills a void. Over many years now there has been no obvious national champion for local audit and this appears to being addressed by the NAGCAE work. Better national audit, more training for local audit staff, sharing of audit resources and best practice, recognition of four fundamental issues – all this makes sense. A direct link to an executive board member/s (for local audit staff) would also be a step in the right direction. However, some of the proposed solutions lack clarity in terms of how they will be implemented. NAGCAE also need to be aware that there will be no 'quick fixes' here and this will take 2-3 years to get right.
Q 10	Do you have suggestions for other components?	We would make the following additional comments: 1) There is a 'leadership vaccum'. National structures: DH, HQIP, NAGCAE and NAGG don't seem to be working together to lead and promote local CA. 2) National leaders don't have a complete picture of what is happening in local audit. This is true of some of the incorrect assumptions made of local audit in the NAGCAE consultation (e.g. all Trusts have audit departments. Audit departments are full of audit staff only and this creates barriers with clinical staff). National leaders would benefit from a 'back to the floor' experience of local clinical audit where they visit local Trusts and see what is happening first-hand

		3) This document feels very secondary care focused. ‘Trusts’ are referenced frequently. How do NAGCAE propose local audit will flourish in CCGs, independent contractors, in social care settings, etc? Not mentioned in the document… 4) NAGCAE have focused on the unhelpful term ‘clinical audit’ on page 3, but not addressed how this will be resolved in the solutions. ‘Clinical audit’ is the internationally accepted term and must stay. What needs to change is how ‘clinical audit ‘ is perceived and NAGCAE’s solutions will help to achieve this. 5) In recent times there has been a tendency to involve local audit staff in many national surveys. In most cases, full results have not been feedback. In other instances, e.g. the survey on whether a professional body of CA staff should be set up – the findings (that there was no desire for such a body) did not tally with the results (the majority of respondents supported the setting up of such a body!). Results of this NAGCAE consultation must be fully and timely presented back to those who have taken time to give their views. This needs to be a truly transparent consultation!