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/

This response is a joint response from all staff in an Acute trust clinical audit department.

Q1	Do you agree with this assessment of the current concerns of audit staff in Trust?]	Generally we do not agree with the assessment of the current concerns of audit staff as detailed in the Consultation on Future of Audit staff in Trusts. Specifically: • There are many demands from numerous sources but we are able to determine priorities – this is not a problem for us. Late additions and deadlines do, however, sometimes pose problems. • Our resources are somewhat inadequate for the workload but the Audit Department is not seen as an easy target for cuts. All Audit facilitator staff have science related degree or have a clinical qualification. • We enjoy good support from management, senior executives and our Trust Board. • We agree that national audit topics are not spread evenly across service areas, that some may be of lower priority within the trust and national audits are repeated sometimes before local improvements can be made. We agree that some are poorly designed but note that HQIP is acting to deal with this. • We work to ensure that all local audits, including those carried out by FT doctors to meet training requirements, are of value to the trust. • Staff tend to value the assessment of quality in national audits where the objectives of the national audit are clear, results are given in a timely manner and recommendations are made; then it is not seen as a tick box exercise. • Clinical audit staff are not diverted to undertake other activities • Clinical audit staff at this trust do not generally collect data; this is the remit of clinicians.
Q2	Do you agree that the current situation is not sustainable?	Better planning by external bodies, including deadline planning for national clinical audits so that these do not all come at once or at Christmas/New Year, would help the Audit Department at this Trust to achieve the large work programme set, both internally and externally. As would ensuring robust audit methodology, reporting and recommendations, to ensure clinician commitment.
Q3	Do you agree with this analysis of the underlying reasons for the current situation?]	We do not generally agree with the analysis. We feel that this is a slightly backward looking view. This analysis identifies 5 specific issues as below: • We do not believe that the term ‘clinical audit’ leads to uncertainly or inconsistency **now.** This may have been the case once but we feel that it is too late to change the term which is now well established and understood.

		• We understand clinical audit to be a tool for use in quality assessment and improvement and certainly appreciate that quality can be improved in a variety of ways and with a variety of tools. • Whilst we have an Audit Department at our trust, we work cooperatively with each clinical division and feel that we have the best of both worlds. We definitely do not feel that having an Audit Department creates an artificial boundary that impedes impact. Each clinical division has its own linked Audit Facilitator who works with clinical staff and the divisional Risk Manager. • The positive issues of having an Audit Department include sharing best practice, sharing audit results across the trust, sharing resources and electronic systems, helps professional development and gives an element of impartiality. • We do not feel that we are isolated and have an active local audit network as well as benefiting from the work that HQIP and the Clinical Audit Support Centre offer. Some duplication of effort probably does exist, however, despite a good track record of sharing and this has been aided by HQIP's work. • There is probably some lack of understanding, skill and experience in improving quality across the NHS and training programmes across the NHS need to address this. At our trust, the clinical audit team will be developing its capabilities in quality improvement in the coming year, with the aim of sharing this with clinical staff.
Q4	Do you agree this would be helpful?	Ensuring that the 2 key components of quality – assessment and improvement – are widely realised would be helpful. At our trust national clinical audits do stimulate quality improvement (through our use of gap analyses).
Q5	Do you agree this would be helpful?	In this section, the title alludes to 'multiple approaches to quality improvement' but the text then discusses only national clinical audits. Our department would never view national clinical audits as 'just collecting data' unless the national clinical audit was poorly conceived. We fully understand the need for large and complex datasets to ensure rigor, an approach we also use for our own local audits. It is not quite clear to what the question alludes.
Q6	Do you agree this would be helpful?	We agree that quality improvement activities could be enhanced by less separation from and more integration with clinical services. Again there are a number of points made here against the one question that is asked: • A major factor in this is the electronic patient record, which will make this possible but for many trusts this is some way off. • We would not be averse to a Quality Department and recognise the advantages but would be concerned lest clinical audit budgets be swallowed up. • We have a lead clinician for clinical audit at our Trust who takes an active role, as does the Medical Director and nursing and therapy colleagues. • We would not want to amalgamate the clinical audit budget with that for Foundation programme doctors time and consultant PAs. • We agree there would be benefits from avoiding drawing a distinction between organisational and clinical practice change and already undertake local clinical audits that include organisational elements (eg ward environmental audits). • We agree that driving quality improvement along clinical pathways is

		required.
Q7	Do you agree this would be helpful?	We agree that it would be helpful to enhance the role of clinical audit staff in quality improvement. This is an issue identified for our development plan for 12/14.
Q8	Do you agree this would be helpful?	We agree that it is helpful to learn from our peers and colleagues in other Trusts. We do this already by participation in our local audit network, with our local Trusts and through HQIP. We agree that it will be useful to engage with existing and emerging organisations such as the Academic Health Science Networks. The 'informal' networks of clinical audit staff that are mentioned, are, in the experience of this department, actually structured and useful, both operationally and educationally. Our Trust has been highlighted by an NCA supplier as a best practice trust, so this system has already started in some quarters.
Q9	What is your view of each component in the proposal?	Component 1: We agree with the statement and consider that these aspects are already in place in our Trust. Component 2: We already have active involvement of clinicians and managers, as well as audit staff, in our Audit Department and have direct access to the Trust board via an executive Board member. We do question whether a large Quality Department would be viewed positively by clinicians and whether it would detract from clinicians taking responsibility for quality within their clinical areas (rather than having the opposite effect that is being proposed). Component 3: We agree that training in national and local policies, technical skills in quality assessment and improvement and behaviour skills in quality improvement should be available for all clinical audit staff. Component 4: We already have many national initiatives and the high level of workload has been raised in the consultation paper. We are therefore wary of agreeing to the requirement for more 'multi Trust' initiatives without seeing the detail. However, we understand that the AHSNs will be important in clinical innovation and quality improvement in the years to come and, together with the R&D function, we would be willing to explore this avenue further.
Q10	Do you have suggestions for other components?	