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?]	I agree partly with this assessment in that there are demands from numerous sources, thereby making it hard to determine priorities, and to ensure we are able to carry out effective local projects. However, I do not agree that there is insufficient support from management etc and feel that in fact over the last couple of years the level of support for audit, certainly within our trust has improved. I do feel that the value of some audits can be questioned but locally we now spend very little time supporting poor quality local audits as our resources are focussed on meeting the national priorities you have identified and on key quality work prioritised by the Trust. Our audit strategy is useful in supporting this direction. I do feel that there are a number of national audits that we are required to participate in which do little on their own to bring about improvement. I don't feel that clinical audit staff are being diverted away from audit to undertake other activities but I believe that our work quite rightly is beginning to link with other quality and assurance work and the value of audit to that end is being increasingly recognised at our trust.
Q2	Do you agree that the current situation is not sustainable?	I feel that the increasing demands for involvement in varying quality of national projects is unsustainable and there needs to be clarity around what is mandatory and what needs to be reported on, for example in the Quality Account.
Q3	Do you agree with this analysis of the underlying reasons for the current situation?]	No, I do not agree with this view. I think this is a describes a trust where perhaps audit teams have work to do to engage with clinical staff, with the support of leaders and a culture needs to be fostered whereby clinicians embrace the support audit teams can offer. I think there are clinicians that see audit and audit personnel in this way but I don't believe it is the majority of clinicians. I don't feel that an audit department

		creates unhelpful boundaries, rather that is shows that a trust gives priority to this work and that clinicians are being supported to participate fully. Work such as the 'A Practical Handbook for Clinical Audit (Clinical Governance Support Team, 2005) explains the benefits of a central team and highlights that this format was recommended in the Bristol Royal Infirmary Inquiry. I also feel in recent years that there is much more of an 'audit community' and although large networks are not effective in all areas there is local interaction and sharing of ideas that is taking place.
Q4	Do you agree this would be helpful?	I do not think it is clear exactly what is being proposed here or what these definitions add to those that already exist, but I agree with the statements.
Q5	Do you agree this would be helpful?	Again, I'm not clear what is being proposed. I don't think it's a lack of understanding from audit staff that is the problem. For example, I worked a lot on MINAP when it was first introduced and I think it is recognised that this national project was very effective. I think any resistance from local staff (both auditors *and* clinicians) to national quality assessment is that there is so much of it now and some projects do not contribute to *'stimulating'* improvement as you highlight they should. The role of clinical leads in influencing involvement and leading change also needs to be considered in relation to this. I think there is an understanding of the benefit good quality, prioritised national projects can bring, but that not all of the 50+ projects we are asked to report on in the Quality Account are of this quality.
Q6	Do you agree this would be helpful?	Although I welcome the motivation and the aim of this approach I do have a number of reservations. I don't feel that all trusts audit departments are working in the way you describe at the beginning of the document and that there is a danger of derailing the good work that is underway if this sort of change is introduced. I believe in the trust that I work in that this can be achieved within existing arrangements. I believe that our central team is integrated with clinical teams and not seen as distinct and existing to audit others, but to support them and the trust as a whole with quality improvement work. Obviously there are always exceptions to this view but by and large

		I think our current system has the benefits of a protected resource of skilled auditors, working in partnership with clinical teams and linking with other key teams such as performance, risk, patient experience, safety and most recently service improvement. I feel that incremental change can be successful in achieving the same ends, and feel locally this is what has been achieved. I do agree that sometimes the distinction between clinical practice and organisational change can be limiting and it might be useful to expand the audit methodology and resource to supporting those projects too.
Q7	Do you agree this would be helpful?	Although I agree that it would be beneficial to provide audit staff with the opportunity to enhance their skills and roles I feel that what you describe can be achieved without major change to the way audit is set-up locally. For example, local leadership opportunities are available to audit staff as will be a developing accredited service improvement training programme, participation in which is built into my teams objectives. Other training opportunities already exist which have not been recognised in this document.
Q8	Do you agree this would be helpful?	Yes, I agree this would be helpful. However, it must be partnership and as far as I am aware there has been no attempt from any of these bodies to engage with audit teams. The onus cannot only be placed on audit teams.
Q9	What is your view of each component in the proposal?	1) I agree, but don't feel that there is any major change required locally in light of this. It is worth highlighting in relation to point 3 of this component that clinical audit staff have a pivotal role in supporting the measurement of quality and working with staff to design and measure the effectiveness of change to improve quality, but ultimately clinical staff and decision makers are responsible for the quality of care provided. 2) I feel that describes the working relationships and structures we have in place, although the managers and clinicians we work closely with, may not be part of the audit department. I would be very reluctant to relinquish our role in undertaking some of the work involved in clinical audit for quality improvement.

		I feel this is hugely appreciated by clinicians and allows them to focus their efforts and energies on aspects of the projects that requires their clinical skill and also by working alongside clinicians we help to improve their skills with all aspects of clinical audit, from deciding on standards to measure, how best to capture the correct data, and on analysing it and reporting it in such a way to help generate improvement. If we could no longer help clinicians on a practical level I do not think they would see it as a positive move at all. In addition the proposal does not recognise or consider the role other departments that contribute to the quality agenda, such as risk and patient experience, and how the function of those teams would need to change if 'quality facilities' were established. 3) Yes, I think it would be very helpful to add to existing opportunities. 4) I think that clinical audit teams can contribute, yes. 5) Yes, I think this would be a useful step, but I do think consideration needs to be given to the number and spread of these projects.
Q10	Do you have suggestions for other components?	I do have concerns that these changes will be disruptive where things are working well. I think that progress has been made in recent years to engage with clinicians and board members to the extent that audit and audit teams are seen increasingly as very important for improving patient care and experience. Where things aren't working well introducing the kind of structure you mention would be useful I am sure, but where the outcomes are being met I am not sure that changing the name or organisation of a department or activity will be useful and is likely to be met with scepticism at best. Large scale change of this nature is likely to cause considerable disruption, destabilise processes that are working well and divert resource from quality improvement while consultation and implementation is underway. I also think that it is important that clinical audit staff's time and resource is still available to assist clinicians and managers with the actual audit process.