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?]	Many of the issues highlighted are valid and there is no doubt that many clinical audit staff are apprehensive about the future - a concern they share with most other staff employed by NHS trusts during this time of unprecedented change. However the assessment does not addresses the key concern of many trusts, which is that too many clinical audits are driven by external requirements, and too many of them have little direct impact on the quality of local services. This includes some of the national clinical audits in the Quality Accounts list and locally agreed CQUINS. Local audit staff also complain of excessive auditing against NICE guidance which is often undertaken in the mistaken belief that it is necessary to meet CQC or NHSLA requirements. Clinicians cannot see the point in such audits, so become disengaged and de-motivated about audit in general, and managers increasingly see audit as a mechanism of increasing income by ticking the CQUINS boxes. Experienced clinical audit staff who want to encourage and promote the use of clinical audit as a quality improvement tool are unable to do so because they have to spend their time on quality assurance projects. Participation in useful and important national clinical audits such as the main NCAPOP projects is taken over by clinical teams, and there are no resources left for clinically important local priority projects.
Q2	Do you agree that the current situation is not sustainable?	Agreed
Q3	Do you agree with this analysis of the underlying reasons for the current situation?]	Point 1 - Clinical audit is clearly defined and understood as a quality improvement process by the vast majority of people who practice it. The problem is that too many projects are labelled 'clinical audit' when they don't meet the definition, and too many audits fail to deliver quality improvement because of poor practice. Muddled thinking about the relationship between clinical audit and other QI processes is a result of poor training in QI, not because the definition of clinical audit lacks clarity. However,

		because of this clinical audit has become devalued by many clinicians and managers tend not to understand that it is a QI process. Point 2 – The message we hear from local audit staff is the exact opposite to this. It is often remarked that national audits **do not relate** to local practice and are not designed to improve practice locally but to provide a national picture. This is said to be particularly true of those designed to collect data continuously. Local trust staff see their roles 'circumscribed and delineated' because of lack of time, resource and local support. Point 3 - If a trust is to meet the statutory and mandatory requirements of the CQC, NHSLA and Monitor, they need a central function where information relating to clinical audit can be collated and managed. If a clinical audit department is not integrated into the governance systems and processes of the trust it can have the consequences outlined; however this arrangement is now uncommon. In most trusts, the clinical audit function has *already* been linked into a larger department which brings together clinical governance, clinical effectiveness, risk management and other functions. Some clinical audit staff are allocated out to clinical departments or have allocated responsibilities for specific clinical services to ensure that audit is integrated into clinical care. The main problem is that the trust may also have a service improvement or service development function which stands separate from clinical audit and sits outside the clinical governance structure. The Mid Staffordshire Hospitals Trust investigation has shown what the consequences of this kind of separation can be. Major changes to service delivery are undertaken with poor clinical engagement and a lack of audit and assessment means that the resulting drop in standards is not acted on. We have observed both centralised and decentralised clinical audit teams and their success, or otherwise, depends on good leadership, good communication and the trust culture. We have always supported the view that clinical audit is a clinically led activity that is supported at trust board level by the

		organisation providing appropriately skilled clinical audit professionals and associated resources. Point 4 – networking matters, and the isolation experienced by staff in some trusts is because these trusts do not support or promote networking. Point 5 – quality improvement skills are poorly developed across the NHS. The multiplicities of agencies and approaches which have been involved in trying to remedy this situation have caused more confusion than clarity. The lack of an integrated system of training about quality improvement and poor teaching of quality improvement in clinical training makes this worse. For audit specialists and clinical leads, we has worked hard to improve the quality of this specific type of quality improvement training. The financial pressures on trusts mean that in some cases quality improvement has been abandoned unless it can be shown to have immediate financial benefits (e.g. achieving CQUINS targets), or is QIPP related. Many of the data collection activities which are imposed on trusts by external bodies or by statutory and mandatory requirements are perceived as burdens, by both the trust boards and by the staff who are required to carry them out. Clinical audit staff resent having to spend time on data collections which have little apparent purpose when they know other local priority projects are not getting the support they need, and clinicians resent using resources on activities which they see little point in when clinical services are being starved of funds. Data collection may be hampered by IT and other technical issues, causing frustration.
Q4	Do you agree this would be helpful?	Creating an artificial distinction between quality assessment and quality improvement is unhelpful and divisive. Quality assessment is of little value if that assessment is not then used to improve practice or demonstrate compliance with regulatory standards or contract requirements. At a time when trusts are under extreme pressure to husband their resources and when trust boards will only sanction actions which have a clear benefit for their patients, any requirement for trusts to collect data must be for an explicit purpose. There is also a problem if quality improvement is divorced from quality assessment. Changes to service provision or clinical practice which are not based on a thorough assessment of current

		practice, and which is not monitored during implementation, are possibly pointless and potentially dangerous. This separation makes an assumption that clinical audit is not already a cycle of quality improvement. We have consistently emphasised that all audit, whether national or local, is a cycle which has measurement and action stages within it. They are not separate processes. To separate out measurement from improvement is unhelpful. National clinical audit providers have to be held responsible for the impact of their activities on local trusts, and the recent HQIP publication 'Principles for Quality in National Clinical Audit' sets out the way in which the interaction between national clinical audit suppliers and local trusts should work. The ultimate aim of any clinical audit should be to deliver benefits for patients, by improving clinical outcomes and making service delivery more effective and efficient. It could be said that the division between quality assessment and quality improvement is part of the problems that this paper has been written to address.
Q5	Do you agree this would be helpful?	It should be the responsibility of national audit providers to ensure that trusts understand the reasons behind such data collections. There needs to be an open and transparent dialogue between national bodies and local trusts over the prioritisation of such projects. The suggestion is not helpful because it patronisingly suggests that local people can't appreciate the value of national audits. They can where there is some point to them. The problem may actually be that from the perspective of the front line of NHS service delivery, what may seem very important to the researcher is really not very relevant at all. Is the burden of collection and analysis to show potentially miniscule variations in outcome between providers really worth the effort if their impact on the front line of the NHS so difficult to appreciate?
Q6	Do you agree this would be helpful?	We cannot see anything within these statements that offers anything new. Audit is linked to clinical teams to a far greater degree than the paper seems to suggest.
Q7	Do you agree this would be helpful?	There are skills training for audit professionals and clinicians listed in paragraph one in 2011. These workshops were oversubscribed and evaluated well. We have also set out a curricula for audit training for audit professionals and clinicians, agreed and approved after extensive consultation by clinical and audit professional groups.

		It is not solely the lack of provision, it is also the lack of trust support to enable individuals to access what training is available. We are aware of many instances where audit staff have funded their own costs and taken annual leave to attend. There appears to be a lack of understanding in this section regarding where clinical audit staff sit in terms of ability to influence. As a very large employer the NHS has always had standardised salary and pay structures, the latest being Agenda for Change (A4C). A4C works alongside the Knowledge and Skills Framework (KSF). Currently, there are two bands for clinical audit professionals without staff management responsibilities (5 and 6). It is only in the band 6 role that there are requirements to have knowledge, training and experience of project and change management. http://www.nhsemployers.org/PayAndContracts/AgendaForChange/NationalJobProfiles/Documents/Public_Health-Health_Improvement.pdf see pages 5 and 9 It is a possibility that many within the clinical audit community will not be open to a greater enhancement of their roles without financial reward. We do agree, however, that training in QI for doctors and other clinicians is very poor, within their pre-qualification courses, in CPD and through specialist training. We have been working to improve this through work with the Deaneries, Foundation Years programme, the Health Foundation and others. We would very much like to see a comparable programme of work on other QI and have argued this in a published paper on our website (see http://www.hqip.org.uk/assets/Core-Team/Position-Papers/03-11-11-Training-paper-Training-and-learning-in-QI-What-should-be-done.pdf.)
Q8	Do you agree this would be helpful?	We agrees that sharing good practice is a good idea and supports clinical audit networks in all regions. Linking with emerging networks may help but all of the networks listed are heavily geared towards research. Audit staff certainly have a role to play

		in implementing research findings but the distinction between research and audit needs to be maintained. Again, it is competing priorities and lack of time that will prevent fruitful engagement. Also trusts may not view clinical audit staff as best placed to enter dialogue at this level.
Q9	What is your view of each component in the proposal?	1. Recognition and acceptance of four fundamental issues • The advantage of distinguishing the two key aspects of achieving high quality services: quality assessment and quality improvement. Strongly disagree – see above. • The complementary benefits of and need for both local and national clinical audits True – providing the impact on local services is considered as well as the national requirements. The case for and value of the NCAs needs to be easier to understand • That quality is the collective responsibility of clinicians, managers and audit staff It always has been e.g. the Darzi report, it is also the personal responsibility of the chief executive. • That clinicians and managers must accept that they are responsible for assessing and improving the quality of the clinical service they run. This is not new. 2. Development of Quality Departments (or Facilities) in Trusts These must have the active involvement not only of audit staff but also clinicians and managers (full-time or part-time, permanent or temporary). Departments will require good leadership (based on ability not profession) and direct access to the Trust Board via a recognised executive Board member. The role of departmental staff is to provide specialist advice, facilitate activities and guide quality assessment and improvement. It is not to undertake the tasks themselves as that is not feasible given the limited capacity of such Departments and need for quality to be addressed and owned by those responsible for any given clinical service in a Trust.

		We do not regard this as any solution to the current problems and may make things worse. The idea that in the present economic climate, trusts will be willing or able to set up such a department is unlikely. It may undermine the work that has happened over recent years to link clinical audit and quality improvement to other areas of governance, particularly, risk management and patient safety, and the existing integration, in so many clinical areas, between audit practice and clinical care. It is true that for too long there has been a perception in trusts that clinical audit is something different to service improvement, and there is real scope for better integration between clinical quality improvement and service redesign. However the solutions to that problem are not about deciding where clinical audit staff should sit – they require a change in the perceptions of senior management and trust boards about the relationship between clinicians and service managers. There is already best practice guidance to boards. What is required is more support for existing clinical audit staff regardless of where their management structure lies. 3. Training opportunities These must be provided for all Quality Department staff (not just audit staff) covering three areas: • Understanding of national and local policies affecting quality agenda • Technical skills in quality assessment and improvement (improvement science) • Behavioural skills in quality improvement (including leadership, change management, facilitation) Agreed – but for all clinicians not just those in the quality department. 4. Establishment of multi-Trust initiatives Quality Departments need to contribute to 'regional' and national activities (such as Academic Health Science Networks which will spearhead clinical innovation and quality improvement in the

		NHS). This will place audit staff in Trusts at the centre of the action with all the associated support, stimulation and energy. The 'centre of the action' will probably be more associated with the Quality Surveillance Groups rather than academic health science networks 5. National clinical audit suppliers Need to increase and improve the ways and extent to which they provide Trusts with feedback on quality (based on rigorous data) and facilitate improvement through well-established means. This requires the development at a national level of knowledge and understanding of the most effective approaches and support for NCA suppliers to adopt and implement best practice. True – but who is going to be responsible for making sure that same is happening for non-NCAPOP audits? There needs to be high quality projects in the first place – much more focused on clinical care. This would make communication of the findings easier and more effective. There is a role for data intermediaries and other QI bodies to help communicate findings and support change locally.
Q10	Do you have suggestions for other components?	There needs to be a thorough review of the obligations, regarding data collections, placed on trusts by national projects and regulators. Any national or regional project which expects local trusts to participate and therefore places demands on local resources must be able to demonstrate the advantages to the local organisations and that the methodology is sound. At the moment a project can be rejected as not appropriate for national funding, but can still advertise itself as a national clinical audit, ask for participation from all relevant trusts. If such a project is on the Quality Accounts list then commissioners and the CQC will put pressure on trusts to participate.