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?]	Mostly yes we agree. There are too many duplicated demands for information from the Trust information department, and various regional organisations. Information requests are often without thought so work is carried out by audit staff repeatedly using slightly different parameters until the requestor receives the answer to the question which was badly constructed in the first place. CQUIN targets in some instances have no significance to the clinicians and have little effect on improving patient quality. The Trust does appear to be more interested in finance than quality. The whole CQUIN exercise seems to be a box ticking exercise to avoid financial penalties. In one instance, data collected over a one year basis proved to be futile, the local commissioners requested the measure to be repeated for another year. However, at the other extreme, we have one measure that will have a significant impact on the patient experience and their journey. It is important that local discussions inform these measures as there is little point in local commissioners enforcing a nationally discussed measure if it has no significance, or no room for improvement locally. It is the local commissioning attitude to CQUIN that undervalues the importance of the measures. Similarly, the CQUIN Quality Dashboards pose a significant workload for what appears to be a data collection exercise as there are no specific improvement targets for the 31 individual measures pertaining to Cardiothoracic Services. However, the local commissioners have insisted that all 31 measures be collected and submitted quarterly. Local CQUIN targets are set without any thought about how the data can be collected or even if it can be collected. Often the targets are very similar to national targets but with just enough difference

		so that the national data cannot be used and this increases the teams workload. Despite the increasing workload, we are seen as an easy target for cuts. People who have left have not been replaced. If people were replaced the hours and grade for the job were reduced. This is very demoralising. Divisional clinical audit does not appear to be a priority at senior level in the Trust. Established and high performing teams are continually being questioned as to the need for their existence despite national recognition for the work being done and major changes in clinical practice brought about by audit work (e.g. primary PCI). This is both demotivates staff and devalues the incredibly important data which informs local and national practice. Local audits don't seem to be valued by junior doctors, except as something they have to do to add to their CV. It is not the junior doctors fault entirely their senior colleagues are asking them to carry out audits that are merely data collection exercises with no measurable standards or with a topic that will not result in any changes to practice. The junior doctors and their senior colleagues are often trying to pass off poor research projects as audits, simply because they want something to publish or use as an abstract at a conference. Our main current concern then is the insufficient ownership and engagement with local audit by senior clinicians. We have a Trust policy on the audit process that must be followed. It's very frustrating that we seem to be regarded as pen pushers merely attempting to follow the trust policy. We spend a lot of time firstly supporting clinicians to actually set standards for an audit and then reports are not returned, requests for action plans are ignored
Q2	Do you agree that the current situation is not sustainable?	Our views in question 1 Increasing workload, too many targets, less staff and poor clinician engagement in local audit, do confirm that the situation is not sustainable.
Q3	Do you agree with this analysis of the underlying reasons for the current situation?]	We don't agree with all of the five specific problems. Clinical audit has been well defined and many books and guides written about what it is. The

		HQIP's websites has educational material that can be downloaded. As a divisional audit team, we feel there is no boundary between us and clinicians. The Trust audit team deals more with Trust-wide issues e.g. Documentation, VTE and we liaise with them on these types of audits avoiding duplication of effort. We do not feel that there is a lack of skills and knowledge but more lack of engagement in the audit process. Again, it's the clinician's engagement with audit. Audit is simple perhaps senior clinicians do not think audit is scientific enough. They always want to do involved statistical analysis and look at demographics etc. They are still more research-orientated. Some clinicians do not attach any great importance to audit work as it is "invisible" in terms of their portfolio. Much more emphasis is given on publications in recognised journals. Medical staff tend to be biased towards research as there is the kudos associated with being published whereas there is no national recognition for improving a local practice. With clinical staff there is the drive to furthering educational standards. Generally, the degree courses focus on research rather than audit as a tool for change (audit dissertations are accepted but the feeling is that they are viewed as being less academic).
Q4	Do you agree this would be helpful?	Not really for us. We feel we already do these things. We are much more than a clinical audit department. We already cover service improvement issues as well as National and local audit.
Q5	Do you agree this would be helpful?	In our division, we feel that clinicians are well engaged in National data sets as they receive feedback internally but less engaged in local audit. Therefore we don't really think this is helpful.
Q6	Do you agree this would be helpful?	Not really re-naming an audit department would just be that, just re-naming. The underlying problems of engaging clinicians would still be there. Clinicians and local staff know that quality is everyone's business but as already stated they do not value the audit process. Likewise, some clinicians do not value the importance of entering high quality data into the national databases and rely on the audit team to clean up the data for them prior to submission. This too demotivates staff, devalues the work carried out and reduces the time that the team can spend on true audit

		work. Data quality must be a key part of the quality assessment at an individual level. As devolved divisional audit team we feel that we are more integrated with the clinicians however the engagement in audit still does not happen, audit teams do not have the power to influence senior clinicians to engage in audit.
Q7	Do you agree this would be helpful?	Audit staff are generally skilled enough but undervalued. Leadership skills are all well and good but change management theory has never changed a non-engaged senior clinician.
Q8	Do you agree this would be helpful?	Very difficult to comment on. My experience is that these such organisations have not filtered down well to clinical practice and can in fact prove "admin" bodies only which can ultimately reflect negatively on clinical audit. However, national recognition of audit work carried out at an individual level, similar to that of research, may incentivise some medical staff to participate (as per Q3).
Q9	What is your view of each component in the proposal?	1. We already know these. 2. Possibly, another talking shop. Perhaps more bottom-up approach rather than top down is needed (or both), 3. Training in leadership, change is fine but you need to be able to have the "power" to change and this often has to come from senior clinicians and management. 4. Great in principle but possibly more work and still poor audits. 5. Most of the feedback from our cardiac data sets is very good. However, some are still poor. Still a need for internal data due to clinicians requests/needs which can be more specific and timely.
Q10	Do you have suggestions for other components?	1. Propose to scrap any target not involving already collected data e.g. national datasets. This would avoid duplication of work. 2. National requirement that senior clinicians should have been involved in a "proper" audit with standards, an action plan and a re-audit to complete the full cycle. 3. A national audit database. We need a standardised way of recording and

		administering local audit, our local database is cumbersome, unreliable and difficult to use and produce any meaningful reports. This would be a better way of reporting audits, a national report template to standardise (and educate) Not just a power point presentation. This would also help to disseminate results and share good practice. 4. National Operating Framework for the NHS in England 2011/12 section 4.34 suggested that the cost subscribing to established national datasets be transferred to providers via tariff. This does not appear to have occurred at a local level as income generation from the 9 national databases contributed to has not been devolved to or influenced local establishment budgets. Contrary to the above, a Department of Health letter dated 18th January 2012 (Gateway Reference Number: 17046) outlined the requirement for Trusts to pay for each of the audits that it subscribed to to a maximum of £23,500. Potentially, these two initiatives cancel each other out – or The Lord giveth and the Lord taketh away! 5. Going back to when the NSF's were created, clinical audit was seen as an essential mechanism for proving that safe and effective clinical practice was being carried out and that the individuals performing that task were fundamental to the running of a well performing clinical division. Now, clinical audit, or in particular, specialised divisional clinical audit is no longer given the credit to its contribution to clinical practice. It has become a hybrid of data collection, clinical audit, information provision and feeding the requirement from commissioners for NICE, CQUIN, etc. Real, completed audit cycles that improve patient care are now a secondary process. Repeatedly for at least the last 8 years, we have had to justify the existence of a good quality locally trained and qualified clinical audit staff. We have been classed as gold standard but are now being told that silver is acceptable. We wish you luck with your endeavours in reinstating clinical audit to the forefront of good clinical care and welcome a time when we can get on with our jobs without a constant concern of job losses or cuts and, more importantly devaluation.