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?]	Only in part. I would not agree that the balance of my work has shifted to data collection.
Q2	Do you agree that the current situation is not sustainable?	Only partially – the whole health service is at risk, not just clinical audit.
Q3	Do you agree with this analysis of the underlying reasons for the current situation?]	No. (1) I would not agree the term clinical audit was a hindrance. Of course it is used in a variety of ways, as are other terms, like "research". However, the problems do not arise from the term – they arise from such normal problems as managerial slackness and the English prejudice against anything other than "financial" management. (2) I would hope most staff are aware of the multiplicity of approaches. The question they will raise is the value for money of the real world national audits. (3) I don't know how you can seriously say this. Clinicians know perfectly well that they have to "do" audit, and that the audit staff are there to support. Clinical audit is one of the GMC duties of a doctor and part of their training. It has always been a standard practice to try and use routinely collected data (if available!). Clinicians may regard national audits as something done to them, but that is an entirely separate matter. (4) This is hardly a problem peculiar to Audit staff. (5) Or to put it another way, their Governance arrangements are poorly developed and supported.
Q4	Do you agree this would be helpful?	No. This looks like an attempt to give the "National Audit" enthusiasts a clear run at number crunching divorced from patient benefit. What is being proposed under (1) seems astonishingly outmoded, separating assessment of quality from its improvement - old fashioned "Quality Assessment" rather than integrating assessment and improvement in

		20th Century Total Quality Management. It would seem particularly important to link assessment to improvement from day 1, so as to avoid the duplication of effort / re-inventing the flat tyre / trying to come up with something after the event, as outlined in Q3 (4) above.
Q5	Do you agree this would be helpful?	I find the question rather insulting. I hope that most staff understand the general principles. That national datasets may need to be large to measure a particular item? No one would dispute that. The question is whether the expense of the data collection represents a good use of the nation's money.
Q6	Do you agree this would be helpful?	No. There are a series of points here. Bullet point 3 - the proposal to abolish Clinical Audit Departments - seems particularly unhelpful. The integrated working of audit staff, clinicians and managers needs to be achieved in the individual clinical departments as part of their governance arrangements. Creating a separate "quality" department won't help – it just causes managerial confusion. If quality is everyone's business, are all the activities of a Trust going to be managed from the Quality Department? Of course not. The key point is for clinical teams to use clinical audit appropriately, and be able to draw on expertise to help them do this. Having a team clearly labelled "Clinical Audit" would seem to be likely to help. I worked in a Trust with separate Audit and Quality Departments and it worked very well. When they tried to merge Audit with other Departments, following the sorts of arguments outlined here, it was an expensive fiasco.
Q7	Do you agree this would be helpful?	Yes – it has already happened. In many cases this would simply be a matter of recognising what was being done by audit staff, not teaching them to do it.
Q8	Do you agree this would be helpful?	Only marginally. There has been useful sharing going on for 20 years. The principal problem is lack of free time for Audit staff. There is no reason to suppose this will improve. Quite the opposite in fact.
Q9	What is your view of each component in the proposal?	Proposal 1 – fundamental issues. The first bullet point seems mistaken. There is nothing new about the other 3. Proposal 2 – Quality should be part of the normal reporting of all specialties and divisions. This is what Clinical Governance is about. Creating a new

		department of quality is just a distraction from this. Proposal 3 – This should already be part of the Trust's work, in line with DH recommendations. To suggest it as something new is a disservice to the DH. Proposal 4 – So the "centre of action" will be these new bodies rather than, God forbid, the patients in their own Trust? Proposal 5 – National audit suppliers should sharpen their acts? Don't suppose anybody will disagree with that.
Q10	Do you have suggestions for other components?	Include explicit reference to existing Clinical Governance arrangements – e.g. for Q9 Proposal 2.