National Advisory Group for Clinical Audit & Enquiries

Response from the Royal College of Anaesthetists to Consultation on Future of Audit staff in Trusts (please note that this response incorporates comments from clinical and lay members of College Council)

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?]	Overall we agree that this is probably a fair assessment of the concerns of audit staff. We agree that audit staff are under mounting pressure and pulled in various directions by their Trusts. Moreover they are also required to provide data to external organisations. This is understandably very difficult to achieve with lack of appropriate resources and there seems to be a need for stronger focus in their function and remit. In addition, we have concern that the current trend in Trusts of reducing the amount of SPA (Supporting Professional Activity) time for Consultants will have an adverse effect on the level of support they can offer to audit staff in essential clinical audits. Patient response - The main purpose of audit should be to inform the improvement of the clinical side of Trusts. The gap between knowing what is so and improvement and sharing of best practice can be considerable.
Q2	Do you agree that the current situation is not sustainable?	We agree, especially in light of the current climate of financial constraints for Trusts, which are likely to affect Clinical Audit Departments. Demands from numerous external authorities and overall fitness for purpose(s) is also a concern.

Q3	Do you agree with this analysis of the underlying reasons for the current situation?]	Broadly yes. Specific comments on the identified 'problems': Despite clear definitions being provided in the past, we agree that perceptions of what audits are can be confused, especially in their relationship to quality improvement. The term 'audit' is also unattractive and associated with checks, especially financial audits. Perhaps the time is opportune for a new definition of clinical audit to link clinical research and quality. A major problem for Consultants in the engagement with audit departments is that non-clinical time has been reduced, while clinical workload has increased. Reduced allocation of SPAs is a major factor in this (see comment in question 1). To compound this QI has been confused with cost saving (e.g. QIPP) and there is a danger this area is therefore being commandeered by managers and financial controllers. There is a need, and hopefully an opportunity, to reclaim clinical QI and make a clear separation between the two. Quality Improvement has not been in curricula until recently - it is not surprising that many medical professionals lack sufficient understanding and lead to frustration in audit staff. Training at all levels is required. However, many clinicians are getting up to speed with Improvement Science very fast and we suspect that this is not equally shared by all audit staff. Specific Patient comments: Problem 1 We would agree that the term 'clinical audit' is likely to fail to engage if it is regarded in the same light as financial audit. Problem 2 Box-ticking approaches and poor attitudes to 'audit' do not promote a climate of engagement by professional staff with quality assessment and improvement. They also waste time which could be better employed in creative

		approaches to assessment. Structural re-design can be become a substitute for a serious, intellectual analysis of what the purpose of the institution is, and how effectively that purpose is being fulfilled. There is a strong parallel with maintained education here, where in the last thirty years all the ostensible debate about education has, in fact, been about structures, not education. Problem 3 Fully agree. The proliferation of audit, best value, human resources departments and others has become a very expensive drain on financial resources, and has separated crucial leadership and management functions from clinicians. This does not help patients. Problem 4 Absolutely. And worse, this leads to much waste of time and personnel. Problem 5 This will vary from Trust to Trust, but sending people on courses will not be the whole answer, especially if these are DoH scripted courses where thinking is often pre-determined rather than open and creative. Clinicians would be perfectly capable of managing quality improvement if they were given the time and were trusted to do it. Whatever happens, clinicians, not 'auditors' must be in the lead.
Q4	Do you agree this would be helpful?	Probably. What we would like to see is clinicians and consultants being more involved in the audit process. The culture of continuous assessment and improvement should be clinician led, supported by audit staff. One medical reviewer suggested doing away with audit departments and replacing them with 'QI departments', which could include Quality assessment, quality improvement, dissemination of best practice (implementation of research) and any audit necessary to support these processes. Some Trusts seem to have moved towards this approach already and this approach is indeed mentioned on page 5 of the consultation document.

		Patient comment - Whatever happens, please let it not be another externally imposed, national blueprint, delineated by non-medical consultants or 'experts'. Stimulation sounds great. What matters is the climate and culture of continuous assessment and improvement, clinician led. Many of the ills of the NHS which have led to poor patient care, have been because the management function of clinicians has been placed in other hands.
Q5	Do you agree this would be helpful?	Yes - the collection of data for national 'audits' is vitally important and audit staff should recognise this. However, there is a need to strike the right balance and consideration to local needs must also be given, for example some national audits may not have local relevance and other QA and QI initiatives might have far greater relevance for local care improvement. Patient comment - Again, this section presumes service re-design. This is not the heart of the matter. Clear and comprehensive data are certainly essential. But data is useless unless the purpose focuses on the quality of patient care and all involved in this on the clinical side have a role in this. Professional leadership involves 'selling' the purpose of data collection to the staff for whom they are responsible, or those whom they are in a position to influence. The key to co-operation in providing data is that everyone should understand the importance of the collection, and not to ask for the same data more than once.
Q6	Do you agree this would be helpful?	Overall we agree with this section. Certainly greater integration of QI and relevant staff with clinicians and managers working together is welcome and necessary. Some hospitals are already moving strongly in that direction (see comment in question 4).

		We are also supportive of the concept that data collection for quality assessment needs to be integrated with the data needs for clinical care – i.e. we need to embed relevant data collection into the routine IT systems so that certain data can be continuously recorded and intermittently audited. The second bullet point, however, seems to make unhelpful statements about consultants 'absolving themselves of responsibility for quality assessment and improvement....'. The experience of the Consultants contributing to this consultation is that they constantly strive to keep up standards of care and they often are doing most of the data collection (in particular in anaesthesia), while audit departments contribute to the design of the data collection.
Q7	Do you agree this would be helpful?	We think that both of these proposals could be extremely helpful. It makes sense that audit staff should receive high quality training, in all the areas mentioned in section 4 of the document. Equally the calibre of staff in audit departments should be of a high standard, provided that the funds are there to employ them. It is perhaps appropriate that the tendency has hitherto been on doctors. Indeed, doctors who engage in audit are equally at risk (or at least the time they can devote to audit is increasingly at risk). And these two elements are connected.
Q8	Do you agree this would be helpful?	It certainly makes sense for audit departments to share best practice. However, there are many types of audit projects and perhaps not all are suitable for sharing. Moreover there seems to be confusion between clinical audits and well conducted clinical research. The former is not a substitute for the latter and the results and data must be used and shared carefully. We also find that sometimes competition in healthcare amongst Foundation Trusts can hinder rather than help the sharing of good practice and knowledge.

Q9	What is your view of each component in the proposal?	Specific comments on the components: 1. We agree with this component. 2. We agree with establishment of Quality Departments and the term 'audit staff' should be replaced with one more aligned with 'quality'. The statement that the role of 'audit departments is not to do the tasks themselves' is probably unhelpful. It's difficult to see how audit staff can have the ability to lead or champion 'change management' without doing some of the work. Clinicians with knowledge of QA and QI may therefore be in a considerably stronger position to lead the QI agenda; something this document does not address in any detail. 3. Training is essential but it has to be resourced and prioritised adequately, i.e. different staff in QI teams require different training and not all members of the QI team need equal expertise in all the fields. We also suggest that training needs to be led by individuals with current 'hands on' experience in hospitals, clinical and management, not 'bought in' external training companies. 4. There are already examples of regional quality initiatives working very well and we support this. 5. Again, there are already good examples of National Clinical Audit suppliers, e.g., Intensive Care National Audit and Research Centre (ICNARC) - all such national bodies have to be adequately resourced.
Q10	Do you have suggestions for other components?	Achieving a multidisciplinary approach in auditing would be useful. Currently nurses, midwives, doctors and probably other groups within a hospital tend to work in isolation. There are so many audits going on that there is 'audit fatigue'. It would be good if there was a higher profile network of leaders in this field to which individual could go and tap into appropriate, useful projects. We would like to see more

		national quality initiatives – the NHS wastes considerable time and effort duplicating work across hundreds of Trusts. We are concerned that there is a reluctance to make some national audits mandatory in Trust. If they are considered important to a specific area, they should be mandatory. We would like to reiterate the need to support consultant time for audit with suitable allocations of SPAs – without this both audit staff and the audit process itself in Trusts is threatened and cannot work. Finally, professional organisations such as Royal Colleges and national societies have an important role to play and the audits they initiate and co-ordinate must be used to strengthen – and indeed guide – local audits. This needs to be made much more explicit.