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?]	Yes Comment: I feel that the demands from numerous sources have a major impact on the quality of work produced. National bodies and management influences in particular can detract from the origins of medical/clinical audit. National clinical audit, particularly, can turn the process into a benchmarking and target exercise, instead of a quality improvement tool for local services.
Q2	Do you agree that the current situation is not sustainable?	Yes Comment: Although Board level recognition of clinical audit is welcome, management and external demands on clinicians to undertake CA activity takes the emphasis away from them improving their own services. For example, collection of data for sources such as CQUINS is mainly management focused and doesn't necessarily hit the spot with clinicians on the shop floor. Many clinicians are not aware of the vast number of sources of demand on both CA and other quality improvement schemes.
Q3	Do you agree with this analysis of the underlying reasons for the current situation?]	Not fully Comment: Clinical Audit may not be the best terminology but to change terminology now would be very disruptive for clinicians. There may be many other ways of stimulating improvements that require data but those involved in subscribing, collecting and sending data have to be aware of outcomes and benefits to be able to recognise and accept that the resource has been worthwhile! I disagree with the concept of 'an audit department' and isolation of audit staff. A balance between 'an audit department' and interaction with clinical departments/staff is required to negotiate boundaries. Easily accessible support is necessary for clinical staff to undertake quality work and centralised records of activity are also an essential aspect for the organisation. The emphasis should be

		on ‘audit support’, regardless of the working position. CA staff are only isolated in the same sense as any other groups of NHS staff. CA is no different to any other smaller organisational service, every Trust will view and run things slightly differently, so other national conferences in other healthcare fields probably have the same issue. National organisations related to CA do attempt to bring staff together fairly successfully given that everybody has a day job. I fully agree that knowledge and skills of managers particularly and in some instances clinicians limits the impact of CA and CA staff. I do think, however, that many clinicians have the knowledge and skills but do not see CA or QI as priority.
Q4	Do you agree this would be helpful?	Yes Comment: I think the quality assessment component is the easier of the two and is not so much of a problem. Following through on Quality Improvement is much more difficult to instil.
Q5	Do you agree this would be helpful?	Yes Comment: Most audit staff do understand the complexity of data required for national datasets and recognise the need for accurate quality assessment, however, many clinical staff and Management don’t! National datasets and quality assessment for local improvements have to be instigated and implemented by clinical staff if they are to happen.
Q6	Do you agree this would be helpful?	Yes
Q7	Do you agree this would be helpful?	Yes
Q8	Do you agree this would be helpful?	Not Fully Comment: I agree that opportunities of learning from other trusts and identifying NCA best practice should be exploited. I am not sure that the emergence of <u>various</u> organisations focusing on quality would necessarily be beneficial. Increasing numbers of organisations relating to quality may lead to dysfunction.
Q9	What is your view of each component in the proposal?	Yes - Recognition and acceptant of four fundamental issues is essential if the quality

		agenda is to move forward. In principle - Development of Quality Departments in Trusts could end up massively expanding the workload of already stretched audit staff. Active roles from clinicians and management may cause some conflicts and detract from the vision – this would need careful managing and means extra responsibility for audit staff. Yes – Training opportunities are essential to underpinning quality assessment and improvement. Although audit staff could expand on their skills, it is predominantly clinicians and management need more training/education, in particular nurses and AHPs during their professional training programmes. In my experience many nurses go on to be managers and have little concept of audit, quality assessment or quality improvement. In principle – Establishment of multi trust initiatives could spearhead clinical innovations and quality improvement, assuming they are well organised and robust in nature. Too many initiatives, as with national clinical audit, is likely to be detrimental to local quality improvement as clinicians, managers and audit staff 'chase their tails' keeping up with them all! Yes - National clinical audit suppliers need to provide robust audit methodologies and datasets, improve their feedback and understand more about local issues to make recommendations for quality improvement that are feasible.
Q10	Do you have suggestions for other components?	The development of Quality Departments needs to engage with healthcare research and innovation. Such Quality Departments should have strong collaborations with R&D.