Clinical Audit Census 2023

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A note from the authors

We would like to take this opportunity to thank all of those who helped us carry out this census in 2023. Suzanne Henderson and the amazing team at Audit Management and Tracking (AMaT) were instrumental in making this project happen, providing encouragement, insights and the IT support for the census. We would also like to thank all those who took the time to complete the detailed census. When setting up this project we were concerned that clinical audit teams would be reluctant to share sensitive staffing data with commercial organisations. It is heartening to see that so many organisations decided to take part and trust CASC and AMaT to mange their data appropriately and ensure all feedback is confidential and anonymous.

Having worked in clinical audit since the mid-1990s, the issue of resourcing for clinical audit has always been a hot topic and many leaders have made bold statements in terms of how they would look into this subject area and provide feedback. We are proud that we have worked with AMaT to go beyond words and provide hard data that the clinical audit and QI community can utilise, assess and reflect on. As you will see, the data shows huge variability of how NHS organisations address staffing for clinical audit. Moreover, this report highlights that clinical audit 'teams' are called by different names, report to different people, undertake different tasks and face a broad range of challenges. There is a lot of commonality, but the variability is fascinating and we encourage you to look at the report detail.

On a final note we would like to 'tip our hats' to all local clinical audit staff. Without your hard work and dedication, local and national clinical audits simply would not happen and patient care would be lower quality and less safe. Clinical audit is an invaluable tool to monitor, assure and improve patient care and service delivery. This report helps explain how that is done across a range of NHS partners.

Stephen Ashmore and Tracy Ruthven
Clinical Audit Support Centre, Co-Directors

Planning the census

In Spring 2023, the Clinical Audit Support Centre (CASC) and Audit Management and Tracking (AMaT) held a number of short meetings to discuss the possibility of creating and running an Audit Census in 2023 to enable participants to feedback predominantly on their local staffing arrangements. CASC have always been interested in resourcing for clinical audit and the AMaT team possess excellent IT skills and were well placed to facilitate the management of the census from a digital perspective.

A set of draft questions were created and these were discussed in detail and amended accordingly. AMaT uploaded an initial set of draft questions onto an online resource and CASC invited a number of respected clinical audit professionals and experts to critique the census and provide feedback. This led to a small number of valuable changes being made before the census was formally launched.

Launching the census

The census was formally launched at the conclusion of the 2023 AMaT Annual conference in Manchester that took place on 18 May 2023. In addition, the census was shared extensively via Twitter and featured in the monthly CASC e-Newsletter. A number of regional clinical audit networks also kindly shared details of the census with their members.

AMaT monitored the returns over the following months and the decision was taken to close the census at the end of August 2023.

Census returns

There were a total of 41 returns.

However, one organisation submitted three separate returns so we contacted the organisation in question to select which census response they wanted to retain. All three were very similar, but for obvious reasons, duplicate responses needed to be managed appropriately.

Therefore, the adjusted total returns = 39. Of these, 34 related to NHS organisations. Five further returns were received from non-NHS organisations. The quality of returns was exceptionally high, i.e. it was very rare for any of the questions in the census not to be answered by those reporting on behalf of their organisation. The subsequent results in this report relate almost exclusively to NHS organisations, but we will create a final full report that will examine all data supplied to the census.

RESULTS:

1. What is the name of the department in which your clinical audit function sits?

Across the 34 NHS organisations who returned census data, there was considerable variability in relation to responses provided for this question. While 'Clinical Audit' featured most prominently, there were 13 returns where the phrase 'clinical audit' did not feature. As you will see from the data below, a high proportion of departments with responsibility for clinical audit were labelled 'clinical effectiveness'. The phrase 'improvement' appeared in less than 20% of census returns.

21/34 (61.8%) included the phrase 'clinical audit'
17/34 (50.0%) included the phrase 'clinical effectiveness'
8/34 (23.5%) included both phrases 'clinical audit' and 'clinical effectiveness'
6/34 (17.6%) included the phrase 'improvement'.

2. With whom does the responsibility for clinical audit sit corporately within your organisation?

In response to this question, one return was marked 'I am not sure'.

Of the remaining 33 returns:

- Medical Director (n=19) 57.6%
- Chief Nurse (n=4) 12.1%
- Chief Medical Officer (n=3) 9.1%

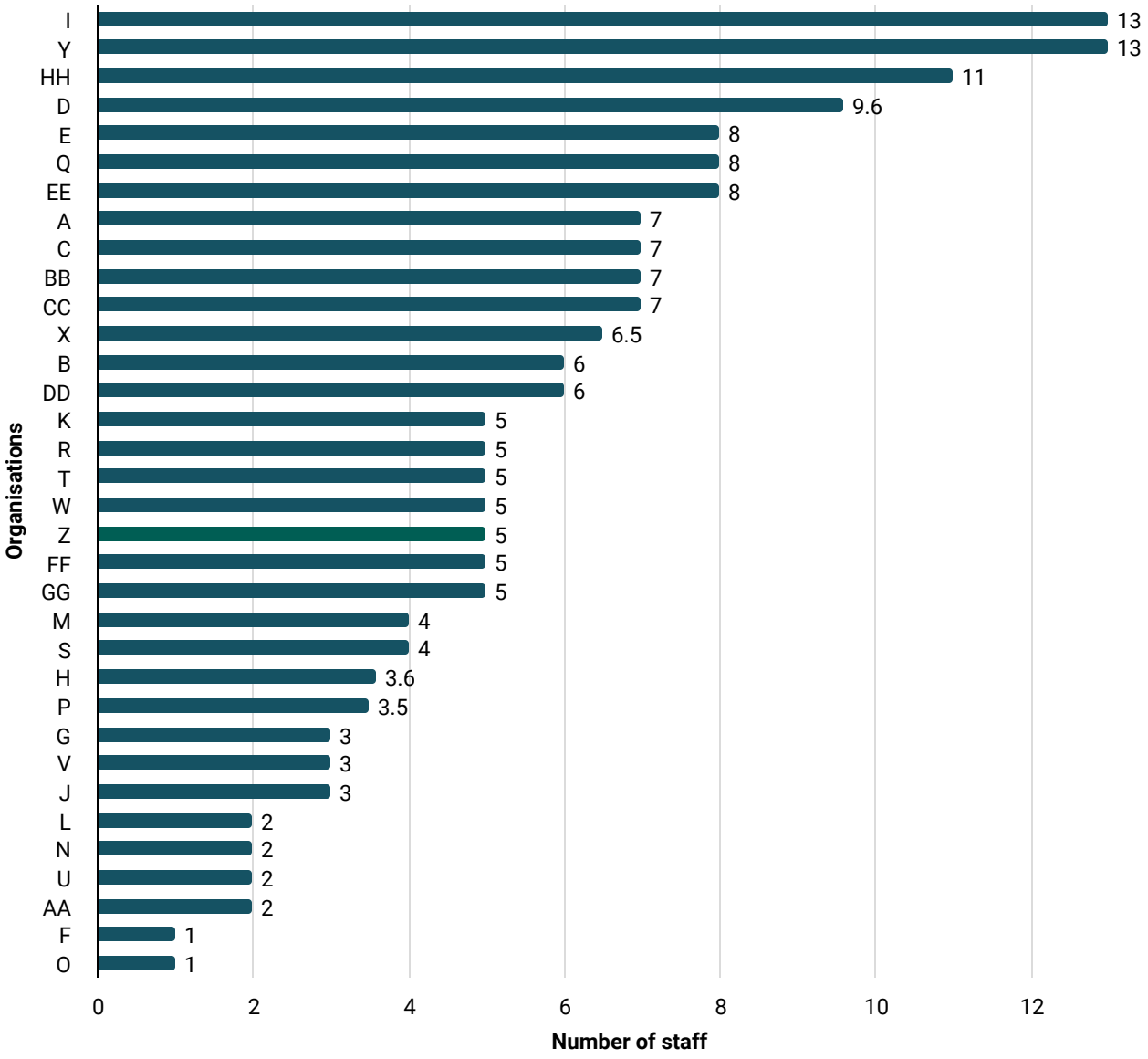
The other answers provided in response to this question all received one return and were as follows:

- Associate Director for Quality Governance and Risk
- Associate Medical Director
- Chief Operating Officer
- Director of Nursing and Quality
- Director of Nursing and Integrated Governance
- Director of Safety and Partnerships
- Governance.

3. How many staff are there who support clinical audit?

It must be noted that the census did not include a specific question asking how many staff supported clinical audit, but instead respondents were asked to list the number of staff by job banding who supported clinical audit. In each case, those responding to the census were also asked to provide the job title for each clinical audit support role. From this data we were able to provide information on the total number of staff per organisation that support clinical audit.

The bar chart below provides a visual representation of the relevant data. Two organisations reported that they employ 13 staff to support clinical audit, while two reported they have just one staff member. The median for this data-set is 5 and the mean = 5.48.



4. Clinical audit staffing by job banding

All organisations that completed the online census were given the opportunity to state how many clinical audit staff were employed at each different NHS pay banding.

The table below illustrates how many organisations (out of a total of 34) employed staff across each pay banding. Therefore, the pay band that was represented most across those who completed the census was Band 5 (73.5%). 61.8% of 34 organisations employing a Band 6 clinical auditor.

Band	No. of organisations	%
Band 3	8	23.5
Band 4	17	50.0
Band 5	25	73.5
Band 6	21	61.8
Band 7	20	58.8
Band 8	18	52.9

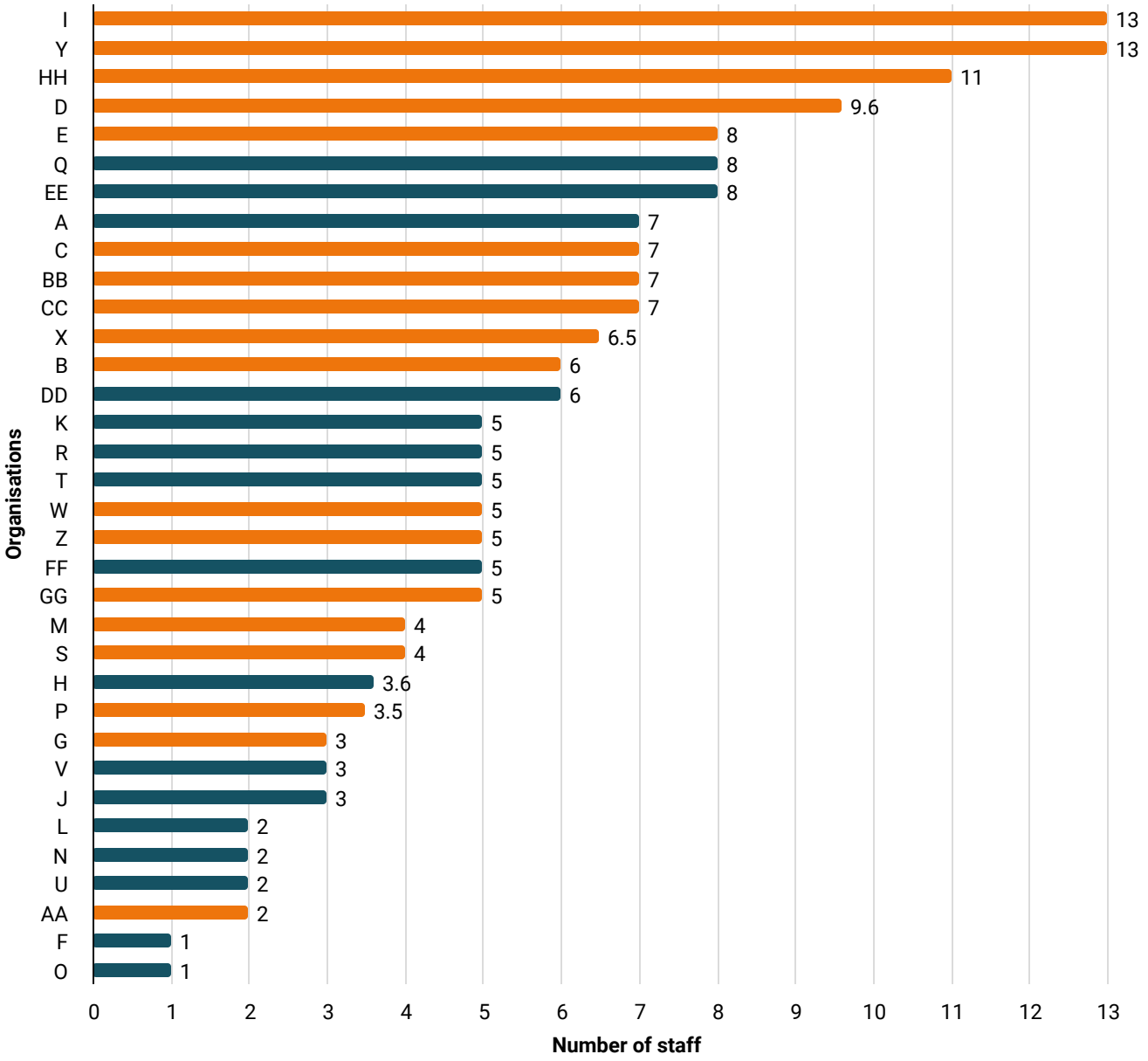
Analysis of the more detailed clinical audit staffing data obtained via the census shows that across 34 organisations, 54.1 WTE Band 5 posts were reported. 37.5 WTE were Band 4, with 36.8 WTE being Band 6. There were 18 organisations who employed a 1.0 WTE Band 8 clinical audit staff member. No organisations reported more than one Band 8 clinical auditor in their organisation.

Band	Total number of staff (WTE)
Band 3	12
Band 4	37.5
Band 5	54.1
Band 6	36.8
Band 7	22.8
Band 8	18

5. Focus on Band 8 staff

As noted previously, just over half the organisations (18/34) who responded to the census stated that they employed a Band 8 clinical audit staff member.

The bar chart below cross references the number of clinical audit staff working within an organisation, with those that employ a Band 8. All organisations employing a band 8 are denoted via an orange bar. For organisations employing a Band 8, the median staff number is 6.25 and the mean is 6.64 WTE.



6. Clinical audit support

All organisations that completed the online census were given the opportunity to provide information on whether or not they provide support in relation to particular stages of the clinical audit process. This data gives us an insight into the work that clinical audit teams perform across organisations. Respondents were asked to identify if they supported staff at six different stages in the audit process.

Do you provide support for	No. of organisations	%
Regular reporting and progress reports	32	94.1
Project advice	34	100.0
Project support: data collection	24	70.6
Project support: data analysis	28	82.4
Project support: report writing	24	70.6
Project support: action planning advice	30	88.2

Of the 34 organisations that participated in the census, 22/34 (64.7%) provided support for all six elements listed in the audit process. These were as follows: regular reporting and progress reports, project advice, project support: data collection, project support: data analysis, project support: report writing and project support: action planning advice.

Conversely, 12/34 (35.3%) organisations did not support at least one of the six elements listed above. In most cases, these organisations did not support 2 to 3 elements and these were most often: project support for data collection and project support for report writing. However, one organisation only supported 'project advice' and two further organisations only supported two of the six elements.

If we cross-reference the size of the 'audit team' here, it shows that for the organisations not supporting all six elements above, their mean staff WTE is 4.42. In comparison, where organisations supported all six elements listed above, the mean staff WTE stands at 6.05.

To see a visual representation of this data, please refer to appendix 1.

7. Training support provided

All organisations that completed the online census were given the opportunity to provide information on whether or not they provide support in relation to training for:

- Clinical audit
- Quality improvement
- Wider systems, e.g. AMaT.

The table below provides the quantitative results:

Do you provide support for	No. of organisations	%
Clinical audit training	31	91.2
Quality improvement training	6	17.6
Wider systems training, e.g. AMaT	11	32.4

While almost all organisations (91.2%) provide clinical audit training for their staff, the census reveals that very few clinical audit teams provided in-house QI training (17.6%). Looking at the data in more detail identifies that of the six organisations to provide QI training, the average WTE for clinical audit staff stood at 5.77. This is only marginally above the average size of WTE clinical audit staffing reported across all 34 NHS organisations that participated in the census. Therefore, it indicates that the size of the audit 'team' is not a determining factor in terms of whether in-house QI training is delivered by clinical audit staff. It is likely that expertise in quality improvement methodologies and local arrangements for supporting QI could perhaps be more relevant factors. For more detail on which teams support QI projects and provide QI training, see appendix 2.

11 out of 34 organisations (32.4%) reported that clinical audit staff provide wider systems training. However, respondents were not asked to provide more clarity in terms of what specific systems training is being delivered.

8. 'Other' clinical audit support provided

All organisations that completed the online census were given the opportunity to provide information on whether or not they provide support in relation to :

- Clinical audit
- National clinical audit
- Nurse assurance audits
- Infection prevention audits
- Pharmacy audits
- NCEPOD.

The table below provides the quantitative results:

Do you provide support for	No. of organisations	%
Clinical audit	34	100.0
National clinical audit	33	97.1*
Nurse assurance audits	19	55.9
Infection prevention audits	16	47.1
Pharmacy audits	17	50
NCEPOD	27	79.4*

Unsurprisingly, all organisations who employ clinical audit staff provide internal support for clinical audit! Almost all respondents identified that their clinical audit staff provide support for national clinical audits (97.1%). On more detailed examination of the data set, the one NHS organisation that answered 'no' to supporting national clinical audit, cannot access any relevant national clinical audits and so in effect all those eligible to take part in national projects, do provide in-house support. Most respondents noted that they help support NCEPOD (79.4%), but again this result is not entirely accurate as not all organisations participating in the census will be eligible to take part in NCEPOD.

The census also asked participants to state whether local audit staff support nurse assurance, infection prevention and pharmacy audits. Responses to these three questions were all very similar with a range from 47.1% to 55.9%.

9. 'Other' support provided

All organisations that completed the online census were given the opportunity to provide information on whether or not they provide support in relation to :

- NICE compliance activity
- Support with baseline assessment, e.g. NICE
- Mortality reviews
- Morbidity reviews
- GIRFT
- Service evaluations
- Quality improvement projects.

The table below provides the quantitive results:

Do you provide support for	No. of organisations	%
NICE compliance activity	28	82.4
Support with baseline assessment, e.g. NICE	27	79.4
Mortality reviews	11	32.4
Morbidity reviews	5	14.7
GIRFT	5	14.7
Service evaluations	25	73.5
Quality improvement projects	17	50.0

The census asked a number of questions focusing on other initiatives and work programmes to see if clinical audit staff help support these or not.

The table above demonstrates that most organisations employ clinical audit staff that assist with work relating to NICE and support service evaluations. Exactly half those surveyed stated that clinical audit staff help support QI projects, which is much higher than the 17.6% that provide QI training.

The table also demonstrates that clinical audit staff appear to be much less involved in patient safety related work programmes, such as: GIRFT, mortality reviews and morbidity reviews.

10. What are your current challenges?

In most instances, the census asked participants to provide quantitative feedback. However, participants were also given the opportunity to list three current challenges via free-text. It is always difficult to analyse and quantify qualitative feedback, but participants identified four main challenges as follows:

1. Capacity and resourcing
2. Engagement
3. Quality improvement related factors
4. Action planning.

The top challenge related to capacity and resourcing and comments received were as follows. Those in bold were ranked number one out of three by relevant organisations responding to the census:

- **Capacity and resources**
- **Capacity to support all the workstreams**
- Department capacity
- Keeping up with sheer amount of audits and actions
- Lack of admin support
- **Lack of capacity to proactively support staff with local / individual projects due to breadth of portfolio and staff resource**
- **Lack of resources to support the mass of continuous national audit submission requirements**
- **Lack of staff, huge workload for a very small team**
- **Lots of workstreams, adhoc work given to the audit department, e.g. CQUINs**
- **Not enough resource or capacity within the CA team**
- **Number of staff in department**
- Resource / recruitment
- **Resource / staffing**
- **Resources**
- **Small team: 1.5 persons supporting 140 teams (approx.)**
- **Staffing capacity - a few years ago we were just the audit team, then we absorbed service evaluations from R&D and have been made the QI team as well, with no extra resource / staff**
- **Time - people power to undertake audit work**
- **Under-resourced for a Trust of this size**
- **Understaffing**
- **Workload capacity including support for improvement projects and delivering QI education.**

What are your current challenges? (continued)

The second ranked challenge from free-text feedback highlighted various engagement issues. The relevant comments are listed below, with those placed first by responding organisations in bold:

- **Clinical engagement**
- **Clinical engagement and ownership of clinical quality and its supporting frameworks. It is important to note that there are outstanding examples of good practice as well as the challenge**
- **Getting engagement from clinical staff other than the Junior Doctors**
- Clinician engagement with improvement planning in response to national audit findings. The next set of results are published before we have had chance to make any improvements and the results are often so old that any improvements made in the year are not reflected in them
- **Getting senior clinical lead support to ensure accuracy of data analysis and interpretation**
- **Engagement**
- Engagement
- Engagement and ownership
- **Engagement at all levels - Effectiveness is a 'necessary evil!'**
- **Engagement in audit and with the clinical audit team**
- Engagement with the clinical teams as the organisation is now made up of two former groups of medical staff who have differing takes on clinical audit
- Engagement with staff to supervise the audits
- Gaining clinical engagement for national clinical audits
- **Lack of engagement**
- Lack of engagement/accountability within site/clinical teams
- Lack of engagement and enthusiasm from some staff, particularly medics
- **Senior clinician engagement and involvement of Clinical Audit**
- **We would like to increase patient engagement further.**

What are your current challenges? (continued)

The third ranked challenge from free-text feedback highlighted various 'quality improvement' issues The relevant comments are listed below and please note that none of the respondents ranked this as their top challenge:

- Competing demands with other QI activity
- Ensuring that audit is valued as an improvement tool
- How we effectively link in with the Continuous Improvement Team / Programme
- Lack of coordination and co-relation between audit and QI teams
- Lack of integration with related activities, e.g. QI, assurance, risk, research, performance
- Interaction with other quality related functions
- Non-alignment of quality functions within trust - silo working within the quality silo itself. Which means we do not share insights or gather different data together to get a bigger, multi-faceted and fuller picture of quality. It is important to note that there are outstanding examples of good practice as well as the challenge
- Not enough inclusion within the wider QI function and be part of wider projects
- Not included in key organisational projects from the beginning (or at all) even when there is a clear role e.g., PSIRF, QI colleagues are given primacy instead
- Poor links with higher profile quality-related depts, e.g. Patient Safety
- Seen as an assurance function not an improvement function
- Top level - the board and senior managers don't understand true QI methodology, they use the phrases, they want to do things in a 'QI way' but actually that's just implementing processes and policies that we should be doing anyway. They want clinical audit as an assurance, but when low compliance levels are found, its difficult to find anyone willing to take on a lead to make the improvements
- Wider team (Quality Team) communication and trust communication.

What are your current challenges? (continued)

The fourth ranked challenge from free-text feedback focused on action planning. The relevant comments are listed below, with those placed first by responding organisations in bold:

- Challenge from higher levels - why are so many projects overdue / why are so many actions overdue?
- Closing audits - getting timely responses on audit reports and QIP actions (AMaT may help ... or at least make the delays visible)
- Closing the loop and actions
- Effective action plans
- Encouraging colleagues to use improvement tools in order to ensure actions taken on the back of audit findings are meaningful and have impact
- Fulfilling action plans
- Gaining impact, as individuals are reluctant to take responsibility for actions
- **Keeping up with sheer amount of audits and actions**
- **Monitoring actions in response to clinical audit results.**

The table below provides more detail in relation to the free-text comments returned as regards the top four challenges identified across the census. Clearly the main challenge reported relates to capacity and resourcing. 20/34 (58.8%) organisations highlighted this as a challenge, with 16 out of 20 listing this first in their response. Challenges in relation to engagement was a close second.

Challenge	Number of comments	Number ranked 1
1. Capacity and resourcing	20	16
2. Engagement	18	10
3. Issues with quality improvement	13	0
4. Action planning	9	2

A significant number of other comments were received in relation to challenges and these will be shared in full via a more detailed report later in 2024.

11. Clinical audit jobs by banding

All those responding to the census were asked to provide details of the job titles for relevant pay bandings. Therefore, the next three pages in this report, list all unique job titles per banding. To help speed up reporting, CA is a pre-fix for 'Clinical Audit'.

The data highlights that job titles attract different pay. As an example, Clinical Audit Manager positions are paid at NHS Band 6, 7 and 8.

Band 3:

- Administrator
- CA Administrator
- CA Assistant
- CA Team Administrator
- Clinical Effectiveness Support Officer
- Clinical Governance Clerk
- Governance Administrator
- NICE and CA Administrator
- Quality Support
- TARN Audit Co-ordinator
- TARN Co-ordinator.

Band 4:

- Administrator
- CA & Effectiveness Facilitator
- CA & Effectiveness Officer
- CA & Improvement Coordinator
- CA & NICE Coordinator
- CA Assistant
- CA Coordinator
- CA Facilitator
- CA Support Officer
- Clinical Effectiveness Administrator
- Clinical Effectiveness Assistant
- Clinical Effectiveness Officer
- Improvement & Effectiveness Project Support Officer
- NICE Coordinator
- TARN Coordinator.

Jobs by banding (continued)

Band 5:

- CA & Effectiveness Facilitator
- CA & Effectiveness Officer
- CA & Improvement Facilitator
- CA Facilitator
- CA Officer
- Clinical Auditor
- Clinical Effectiveness & Improvement Facilitator
- Clinical Effectiveness Facilitator
- Clinical Governance Coordinator
- Deputy CA & Effectiveness Manager
- Improvement Officer
- National Audit Facilitator
- NICE Guidance Coordinator
- Project Support Manager
- Quality Improvement & CA Facilitator
- Senior CA & Effectiveness Facilitator.

Band 6:

- Assistant Patient Safety Officer - CA & Quality Improvement
- CA & Effectiveness Coordinator
- CA Lead
- CA Manager
- CA Supervisor
- CA Team Leader
- Clinical Effectiveness Facilitator
- Clinical Effectiveness Project Lead
- Clinical Governance Facilitator
- Deputy CA Manager
- Improvement & Audit Lead
- NICE Lead
- Quality Projects Lead
- Senior CA Facilitator
- Senior Clinical Effectiveness Facilitator
- Senior Quality Improvement & Clinical Effectiveness Facilitator
- Specialist CA & Improvement Facilitator.

Jobs by banding (continued)

Band 7:

- Audit & Guidelines Midwife
- CA & Effectiveness Manager
- CA & Assurance Manager
- CA & Effectiveness Coordinator
- CA & Improvement Manager
- CA Manager
- Clinical Effectiveness & Audit Manager
- Clinical Effectiveness Lead
- Clinical Effectiveness Manager
- Clinical Effectiveness Project Manager
- Deputy Clinical Effectiveness Manager
- Deputy Head of Clinical Effectiveness
- Head of Clinical Effectiveness
- Improvement Manager
- Mortality Governance Manager
- Patient Safety Officer - CA & Quality Improvement
- Quality Lead
- Senior Quality Improvement Lead.Senior CA & Effectiveness Facilitator.

Band 8:

- CA & Effectiveness Lead
- CA Manager
- Clinical Effectiveness Manager
- Clinical Effectiveness Unit Manager
- Head of CA
- Head of CA & NICE
- Head of CA & Effectiveness
- Head of Clinical Effectiveness
- Head of Compliance & Effectiveness
- Head of improvement
- Improvement Lead
- Quality & Assurance Manager
- Quality Improvement & CA Manager
- Senior Improvement Manager – Clinical Effectiveness & Knowledge.

12. Commentary and future plans

This report provides a unique insight into local staffing arrangements for clinical audit across NHS organisations in 2023. We are grateful to all those who took the time to complete the online census and share their data. We are grateful that individuals and teams who took part in the census feel that they can trust CASC and AMaT with their data returns.

The purpose of the census and this report is to help the clinical audit community better understand staffing arrangements for clinical audit. It is not for CASC and AMaT to interpret the data returned via the census, our role is to simply showcase the results and share these with you. When setting up the census we expected the results to be fascinating and on that level we have not been let down. The various tables, charts and comments shared in this report are intriguing!

Of course no census or survey is perfect and we note that in hindsight we would change a few questions that we asked in 2023. This report focuses almost exclusively on NHS organisations and there is little reference to the five non-NHS organisations who diligently completed the census. Rest assured, a further report will be shared in the next few months that represents complete data sets from across all 39 organisations that took time to complete the census.

In terms of future plans for the census, these are as follows:

1. We will share this report on the CASC website and make it publicly available. While the report is currently in draft format, we will work hard in coming weeks to re-check the data provided and share a final version soon

2. We will work on the additional data provided by non-NHS organisations and add this into a complete final report. The final report will also include all free-text responses

3. Later in Summer 2024 we will run a CASC Learn at Lunch session and present the census data. This will provide interested parties with the opportunity to ask questions and discuss the results in an open forum. The Learn at Lunch session will be recorded so those unable to attend will be able to watch this back

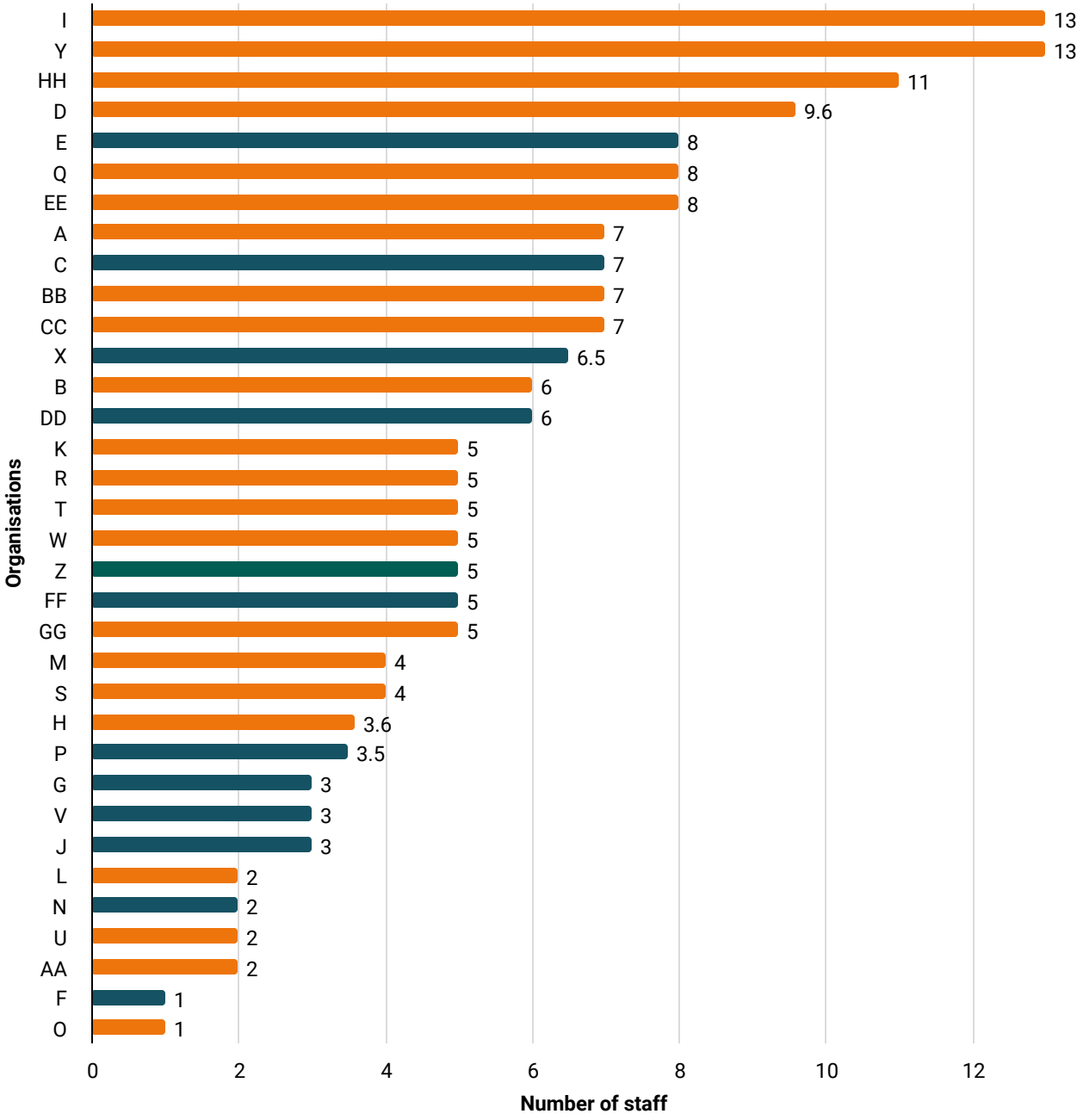
4. We are exploring the opportunity to publish this work as we aren't aware of a similar census or survey that has focused on staffing arrangements for clinical audit

5. We will be working with AMaT to explore the possibility of running the census again at a future date. This would allow us to compare results from 2023 with a subsequent timeframe.

Appendix 1: Clinical audit support

The bar chart below provides further detail in relation to the six questions (see page 8) that relate to support for clinical audit.

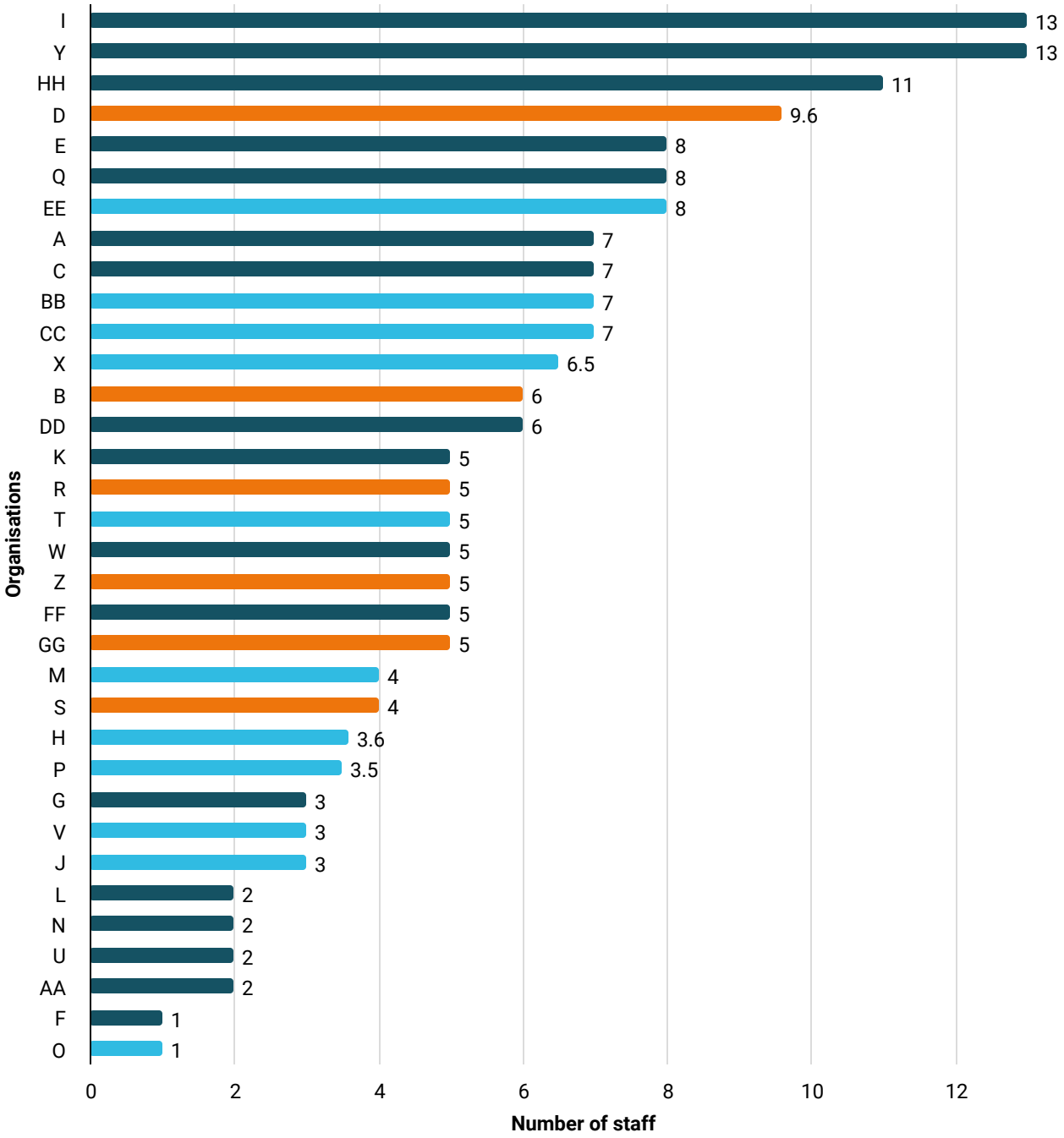
The organisations in orange provide support for all six elements listed as follows: regular reporting and progress reports, project advice, project support - data collection, project support - data analysis, project support - report writing and project support - action planning advice. The organisations in blue do not provide support across all six elements listed above in relation to clinical audit.



Appendix 2: QI project support and QI training

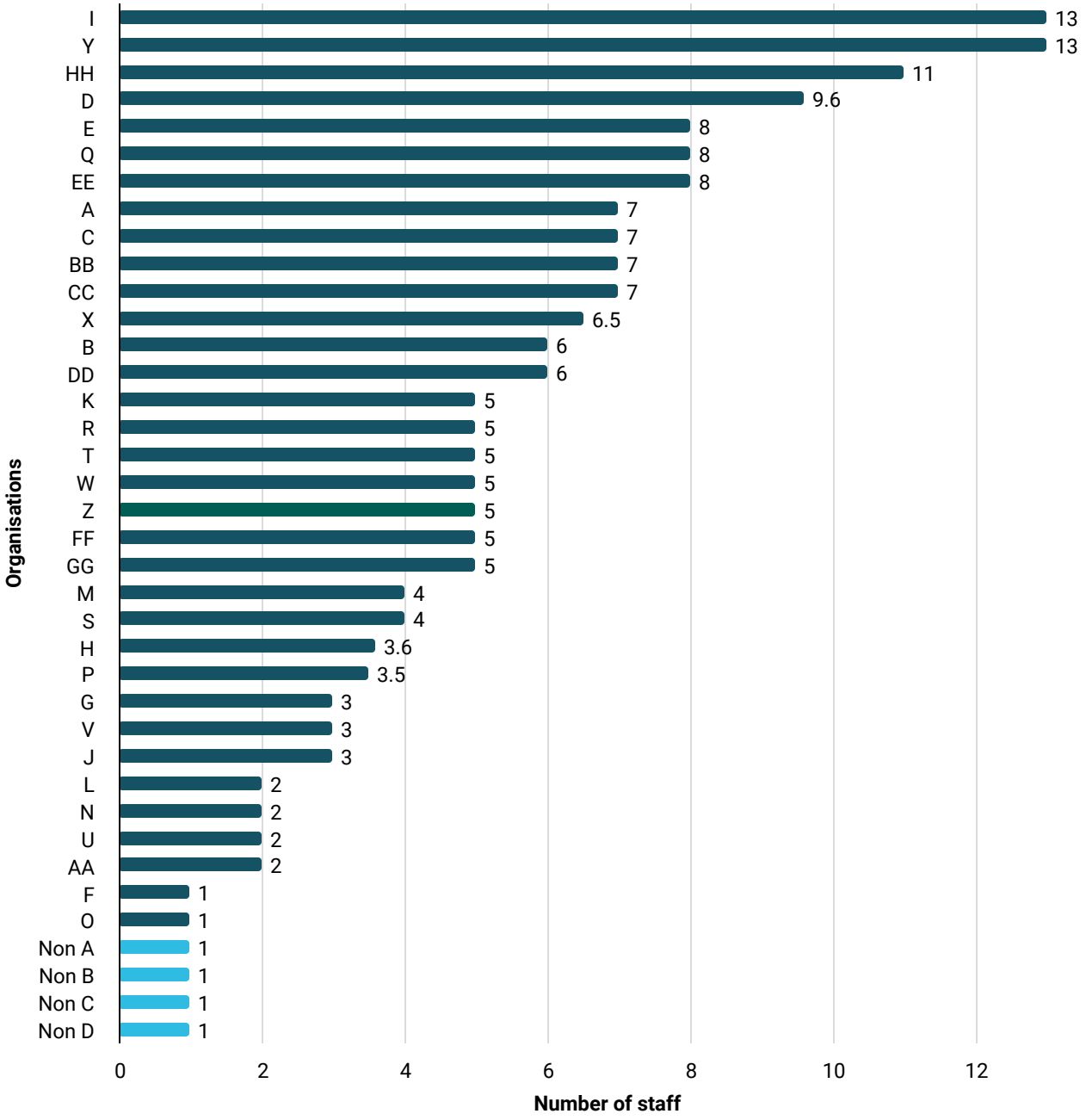
The bar chart below provides more details in relation to which organisations provide QI project support and QI training in comparison to the number of clinical audit staff employed.

The bars marked in orange highlight the organisations that stated they provide both QI project support and QI training. The bars marked in light blue represent those oganisations that provide only QI project support. The dark blue bars represent teams that don't provide QI project support or training.



Appendix 3: Non-NHS data

While this report has focused almost exclusively on those 34 NHS organisations that completed the census, there is useful data to feedback on the 5 non-NHS organisations that completed the census. To protect anonymity, we can't provide further details on what types of organisations these were, but they are a mix of charities and commercial entities. One organisation stated they employed an audit staff member on 'an other' pay banding and in this case it is not known how many clinical audit staff that organisation employ. For the other 4 non-NHS respondents, all employ one staff member to support clinical audit and bandings were as follows: Band 8 (1), Band 7 (1) and Band 6 (2). Based on these returns, clinical audit support in non-NHS teams seems to fall to the responsibility of one person.



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