The state of clinical audit

11th annual survey
Final report
Published: November 2021

'Without data, you are just another person with an opinion'
W. Edwards Deming

Clinical Audit SUPPORT CENTRE

www.clinicalauditsupport.com

Background

Since December 2010 the Clinical Audit Support Centre (CASC) have conducted an annual survey aimed at healthcare staff with an interest in clinical audit. CASC introduced the survey to help measure the Chief Medial Officer's "reinvigoration of clinical audit" initiative that was launched in 2006. CASC devised the online survey and now have nine years of comparable data. CASC set up the online questionnaire via SurveyMonkey and various invites to participate were sent out in November 2020. For example, CASC sent an e-postcard at the start of November to a random selection of more than 1,000 individuals with an interest in clinical audit inviting them to participate. Thereafter the survey was widely publicised via a range of clinical audit resources, networks and services. We also piggybacked the survey onto Clinical Audit Awareness Week #CAAW20. The survey was open from the start of Clinical Audit Awareness Week (which started on 25 November) to Christmas Eve 2020. We would like to thank all those who helped promote the survey.

It should be noted that in 2020, we made one amendment to our survey compared to 2019. This involved taking out a series of questions that we included to assist Marina Otley and Roger Simpson (East Midlands Clinical Audit Support Network members) in their quest to improve the quality of information provided by national clinical audit suppliers.

Response rate and respondents

Participation in the survey is optional. A total of 187 returns were received. Given that individuals may have forwarded the initial e-postcard to other colleagues or been made aware of the survey via a number of different routes it is impossible to calculate the exact response rate. Equally, it is not known how many people work in clinical audit or who have responsibilities for clinical audit. The response rate of 187 returns represents a small increase compared to 161 in 2019 and 183 in 2018. It should be noted that this is the eleventh consecutive year with more than 100 responses.

As stated above, minimal personal data was collected as part of the survey. Respondents were asked a number of broad demographic questions, as follows:
1. How would you classify yourself (possible answers: 'clinical audit professional', 'clinical governance professional with responsibility for clinical audit', 'clinician with interest / responsibility for clinical audit', 'quality improvement professional with responsibility for clinical audit', or 'other').
2. How long have you worked in clinical audit? (possible answers in years: 'Less than 5 years', '6-10 years', '11-15 years' or '16+ years').
3. What sector do you work in? (possible answers: 'acute care', 'ambulance', 'community', 'mental health', 'partnership' (community and mental health), 'primary care' or 'other'.

Of the 187 respondents for section 1, the vast majority (55.6%) classified themselves as a 'clinical audit professional'. The majority of respondents stated that they worked in 'acute care' (57.4%). Years worked in clinical audit was varied with 35.9% stating they had worked in the profession for 5 years or less. However, 45.1% of respondents had worked in clinical audit for 11 years or more. Throughout the survey the quality of responses was extremely high with very few missed answers. This has been a consistent finding ever since we set up the survey in 2010.

Section 1: Demographic results

The following section, provides results for the three 'demographic' questions in the survey. Therefore, this page gives details of the data collected in terms of who the respondents to the survey are.

Q1 How would you classify yourself?

All respondents answered Q1, leaving n=187:

Clinical audit professional	(104)	55.6%
Clinical governance professional with responsibility for clinical audit	(39)	20.9%
Quality improvement professional with responsibility for clinical audit	(19)	10.2%
Clinician with interest/responsibility for clinical audit	(9)	4.8%
Other*	(16)	8.6%

*For full transparency we have listed all supplementary comments for those who answered 'other' to Q1 in the appendix section later in this report.

Q2 How long have you worked in clinical audit?

3 respondents skipped this question and 5 answered 'not applicable', leaving n=179 answer for Q2:

Less than 5 years	(66)	36.9%
6 to 10 years	(30)	16.8%
11 to 15 years	(39)	21.8%
16 years or more	(44)	24.6%

Q3 What sector do you work in?

4 respondents did not reply to this question, leaving n=183 who answered Q3:

Acute care	(105)	57.4%
Ambulance	(7)	3.8%
Community	(18)	9.8%
Mental health	(22)	12.0%
Partnership (community and mental health)	(12)	6.6%
Primary Care	(2)	1.1%
Other*	(17)	9.3%

*There were a wide range of 'other' answers listed for Q3. For full transparency we have listed all supplementary comments for those who answered Q3 'other' in the appendix section.

Section 2: Main results

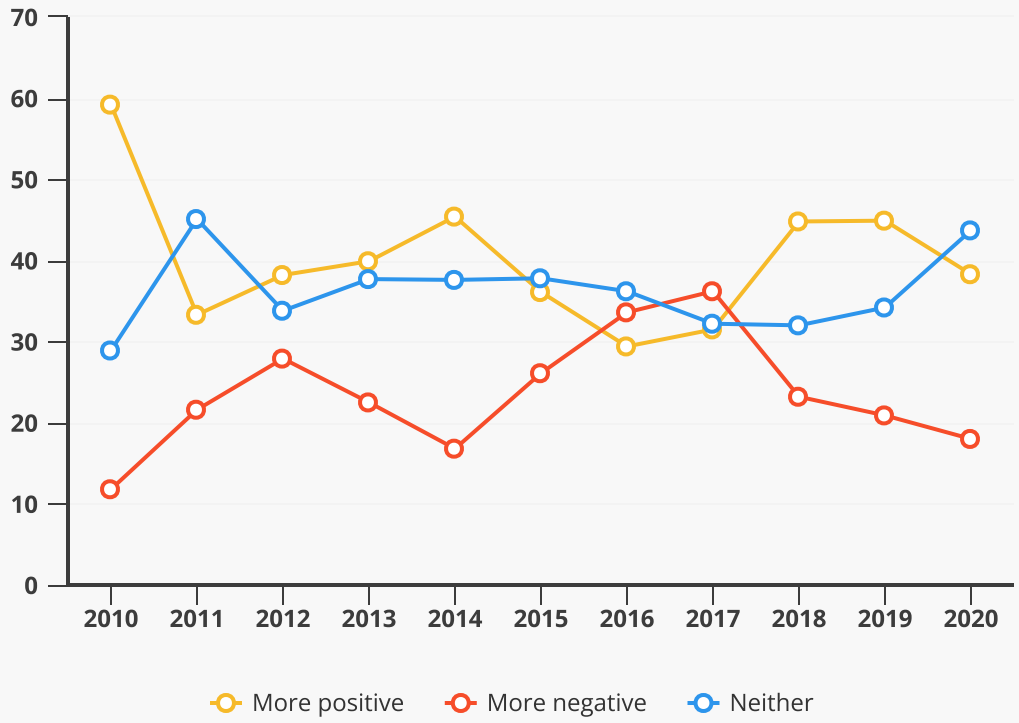
The following section, provides results for questions that were asked as part of the CASC survey.

Q4 Do you feel more positive or more negative about clinical audit than you did a year ago?

4 respondents did not reply to this question, leaving n=183 who answered Q4:

More positive	(70)	38.3%
More negative	(33)	18.0%
Neither more positive/negative	(80)	43.7%

The graph below illustrates the significant changes in results over the last eleven surveys. When the survey was first carried out in 2010, 59.2% of respondents answered this question 'more positive' compared to just 11.8% 'more negative'. However, in subsequent years the proportion of 'more negative' responses increased to a point where in 2016 and 2107 the number of 'more negative' responses exceeded the 'more positive' replies. It is encouraging to see that for the last three surveys from 2018 to 2020 the number of 'more positive' answers has outweighed the proportion of 'more negative' responses by approximately 20%.



Q5 Do you still intend to work in clinical audit in 5 years / or have responsibilities for clinical audit in five years time?

4 respondents did not reply to this question, leaving n=183 who answered Q5:

Yes	(118)	64.5%
No	(65)	35.5%

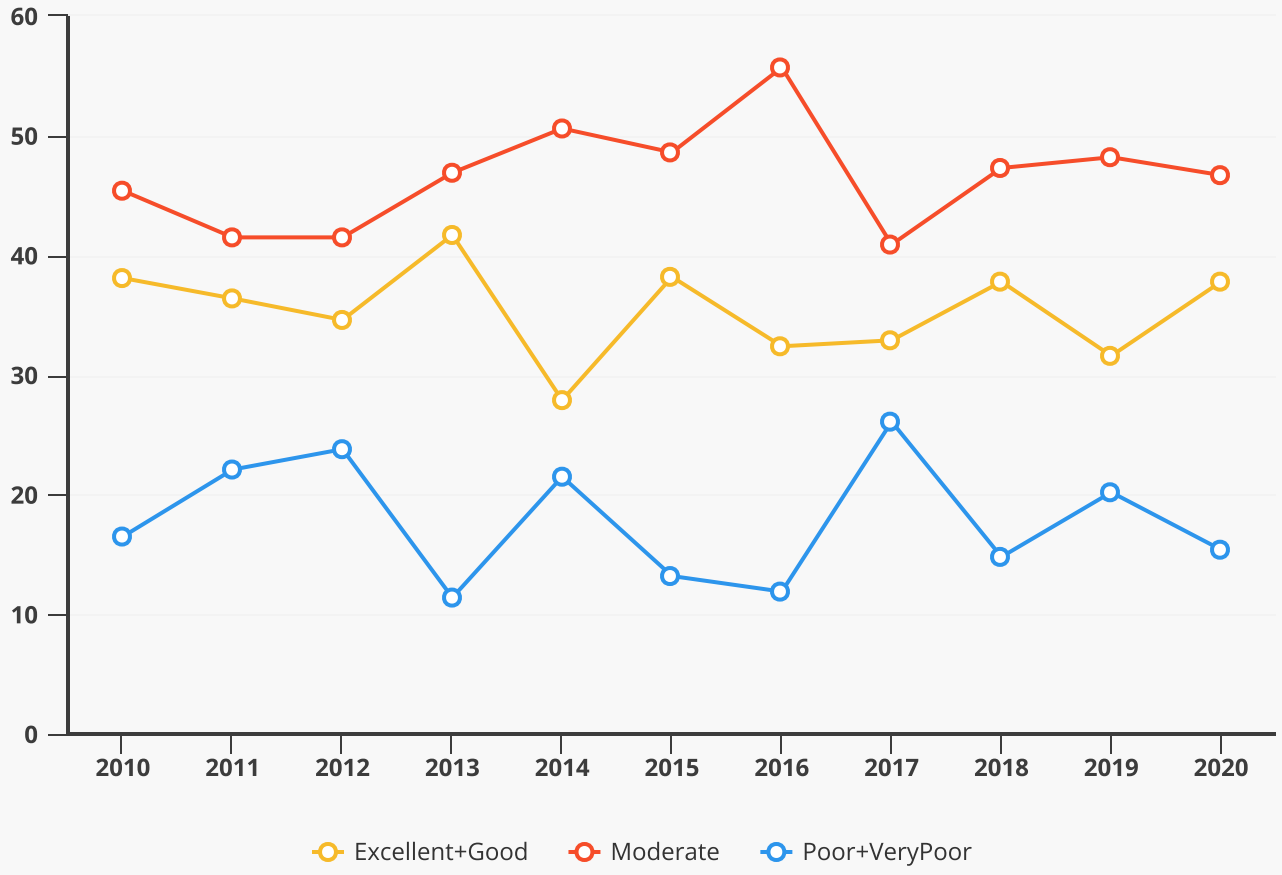
64.5% of respondents for Q5 stated they intended to work in audit in 5 years. This represents a 5.8% increase compared to 2019.

Q6 Overall, how would you rate the quality of National Clinical Audit (NCA) projects that you have taken part in?

44 respondents did not answer Q6 (6 skipped the question while a further 38 marked the 'not applicable, I have not taken part in national audits' option). Results for the remaining 143 respondents are as follows:

Excellent	(11)	7.7%
Good	(43)	30.1%
Moderate	(67)	46.7%
Poor	(12)	8.4%
Very poor	(10)	7.0%

The graph below shows for the eleventh consecutive survey the highest response to this question (even when 'excellent' + 'good' and 'poor' + 'very poor' responses were grouped together) was 'moderate' (46.7%). Results are consistent across the ten years of data collection (2010 to 2020) and this is shown by the fact that none of the lines on the graph have ever over-lapped. Results for 2020 convey a slight improvement when compared to 2019, but are almost identical to the results reported in 2018.



Q7 What do you consider to be the **most** effective national clinical audit?

All respondents were given the opportunity to provide qualitative data in relation to this question in the survey. Note: 44 respondents did not answer Q6, leaving 143 eligible to answer Q7 and Q8. 108 out of 143 respondents (75.5%) supplied an answer for Q7a. The top five listed audits were:

Sentinel Stroke National Audit Programme (SSNAP)	16
National Emergency Laparotomy Audit (NELA)	12
National Audit of Psychosis (NCAP)	9
College of Emergency Medicine Audits (RCEM)^	8
Prescribing Observatory for Mental Health (POMH)^	8

^It should be noted that the RCEM and POMH results incorporates a number of audits.

For the eleventh consecutive survey, SSNAP received the most nominations in response to this question. Results for 2020 are similar to 2019 with the top two national audits in the same order as last time. The number of votes between first and second remains small.

Q8 What do you consider to be the **least** effective national clinical audit?

In total, 90 out of 143 respondents (62.9%) provided details of a national clinical audit in response to Q8. As in 2019, most national audits received very few votes in response to this question. We have listed those NCAs that clearly received 4 or more votes:

National Audit of Psychosis (NCAP)	10
Falls^	6
Myocardial Ischaemia National Audit Project (MINAP)	4

^It should be noted that there are a number of national audits that focus on falls but the responses were not clear which audits they related to.

While we have included Q8 in out survey every year since we commenced this work in 2010, we can advise within this report and in advance of the 2021 survey, that this question will not feature again. In most cases the national audits nominated in this category receive comparatively few votes. it is also noticeable that over the years the leading NCAs for Q8 have received less votes than those nominated for Q7. We also feel that going forward we want to focus on the positives and benefits of national audit and it is clear that our free text questions focusing on national audits supply more than enough information in terms of how national audit can be ineffective and needs to change and improve.

Q9 Within your current organisation, would you like more or less national clinical audits to be made available?

64 respondents did not answer Q9. Of the remaining 123 respondents, the results were:

More national clinical audits	(48)	39.0%
Less national clinical audits	(75)	60.1%

However, this result is crude and unsophisticated owing to the fact that it includes all 123 respondents, but without any appreciation of their workplace. For example, those working within acute care are expected to participate in a considerable number of mandatory NCAs. In comparison, those working in community care and mental health only have access to a relatively small number of NCAs. Therefore, to provide more detailed insights, the results have been broken down further into smaller cohorts of respondents.

76 respondents (out of a possible 105) stated that they worked in acute care and answered Q9. The results were as follows:

More national clinical audits	(18)	23.7%
Less national clinical audits	(58)	76.3%

In comparison, the results for the 38 respondents (out of a possible 52) working in either mental health, community care or partnership, were as follows:

More national clinical audits	(25)	65.8%
Less national clinical audits	(13)	34.2%

By breaking down the data into small groups, we get a better picture of respondents current views towards national clinical audit.

Further comments in relation to National Clinical Audits

As part of the survey, we also asked respondents for more detailed opinions / feedback in relation to their wider views on National Clinical Audits. These took the form of three free-text questions, as follows: a) what is the single best attribute of national clinical audits? b) what one change would you make to improve national clinical audits? and c) within your organisation would you like more or less national clinical audits to be made available?

These three free-text questions have proved popular, with many survey respondents choosing to answer and provide feedback. Analysis of free-text is notoriously difficult to do and this year we have decided not to provide our interpretation of the comments. Page 8 provides more details and we encourage you to read all the comments submitted and make your own judgements in terms of what this feedback tells us about national clinical audit.

Q10 What is the single best attribute of National Clinical Audits?

As in previous years there was a range of responses in relation to this question. However, it is once again clear that respondents identified benchmarking as the main best attribute for national clinical audits and the word 'benchmark' or 'benchmarking' appears regularly in the free-text answers that you will find on pages (21 to 23) where all comments in relation to this question are located.

In previous years the CASC team has attempted to analyse the free-text responses given in relation to this question. However, this year and going forward with future surveys, we feel it is important that those looking at our annual report read and assess the free-text comments themselves. The quality of comments and richness of information supplied by survey participants is extraordinarily insightful.

Q11 What one change would you make to improve National Clinical Audits?

Once again we provided survey participants the opportunity to make suggestions in terms of how national clinical audits could be improved and once again respondents did not disappoint us! The comments to be found on pages 24 to 28 suggest a wide range of ideas and initiatives that could ultimately improve national audits and the national audit programme.

The quality and depth of comments and suggestions is exceptional. It is clear that many of those responding to the survey have vast experience of taking part in national audit and are passionate when it comes to recommending tweaks, changes and improvements.

Q12 Within your organisation would you like more or less national clinical audits to be made available?

It is fascinating to note and observe that of all the free-text questions asked via this survey, the one that generates the most detailed responses is this question that asks if people want 'more or less national clinical audits to be made available. As you will see, the volume of free-text extends to six full pages and you can read all comments via pages 29 to 34 in this report.

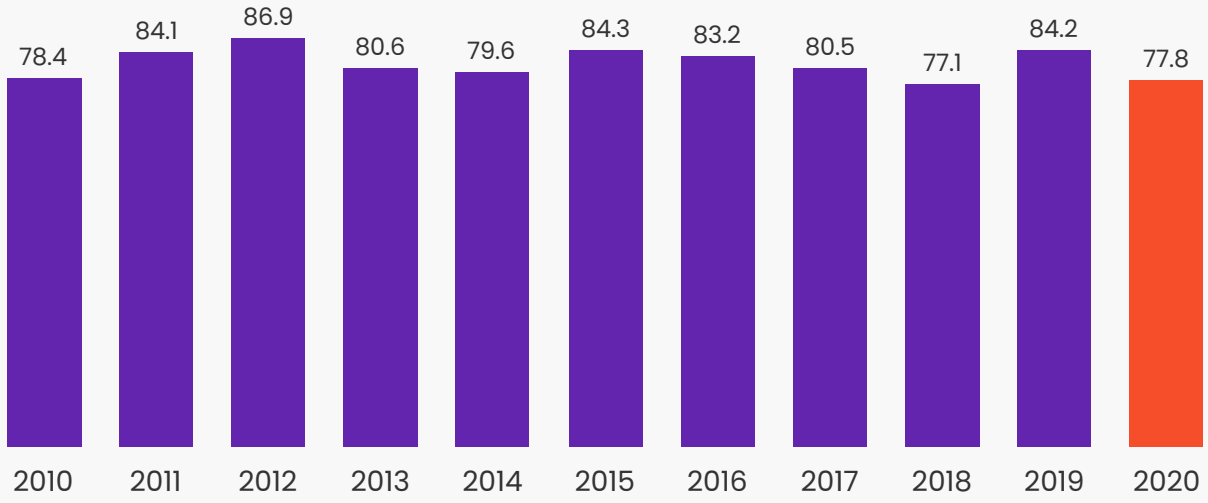
We can only thank those who have taken the time and effort to give their thoughts in relation to this question (and others in the survey). As you will see, the length, depth and detail some respondents have provided in relation to this particular question is extraordinary.

Q13 In your opinion, which are the more effective at improving patient care?

34 respondents did not answer, leaving n=153 for Q13:

Local clinical audit	(119)	77.8%
National clinical audit	(34)	22.2%

For the eleventh consecutive survey, local clinical audit outscored national clinical audit by a significant margin. The result for 'local clinical audit' in 2020 represents a decrease of 6.4% when compared to 2019. It is the second lowest 'vote' for local audit with only 2018 (77.1%) recorded a smaller total percentage.



Q14 To your best knowledge or best approximation, what proportion of local clinical audits initiated in your organisation result in a re-audit being carried out?

35 respondents skipped this question, leaving n=152:

0% to 20%	(26)	17.1%
21% to 40%	(54)	35.5%
41% to 60%	(34)	22.4%
61% to 80%	(27)	17.8%
81% to 100%	(11)	7.2%

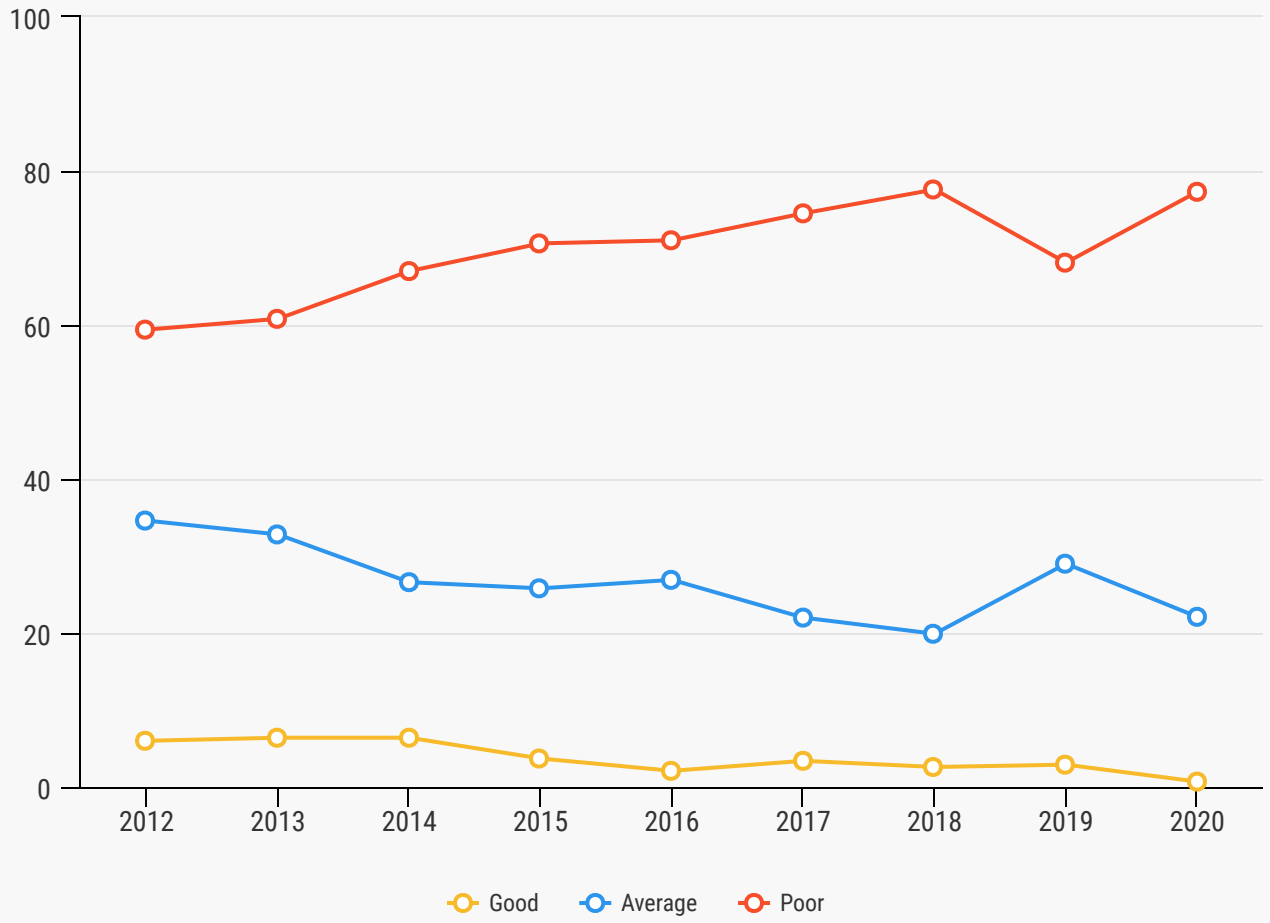
We appreciate that there is subjectivity with Q14, e.g. some teams carry out traditional full-scale re-audits, whereas others conducted targeted re-audits. The results for 2020 are similar to those reported in previous years and identify there is scope to improve re-audit rates.

Q15 Over the last 12 months, how would you rate the level of patient involvement in clinical audits you have taken part in/facilitated?

33 respondents skipped this question, leaving n=154:

Good, patients are heavily involved in clinical audit	(1)	0.7%
Average, patients are involved in some aspects of clinical audit	(34)	22.1%
Poor, patients are rarely involved in clinical audit	(119)	77.3%

This question was introduced in 2012 as CASC wanted to measure views on patient involvement as this was first recommended by the Department of Health in 1994. In addition, Healthcare Quality Improvement Partnership (HQIP) best practice documents have consistently highlighted the need to involve patients directly in clinical audit. Results in the graph below illustrate that for our surveys since 2012 the majority of respondents rate patient involvement in clinical audit as 'poor'. Indeed, in 2020 only ONE respondent out of 154 marked their answer to this question as 'good'. It should also be noted that compared to 2019, the percentage of respondents who responded with 'average' dropped from 29% to 22.1%. These results represent the lowest levels of patient involvement in clinical audit since we started collecting this data in 2012.

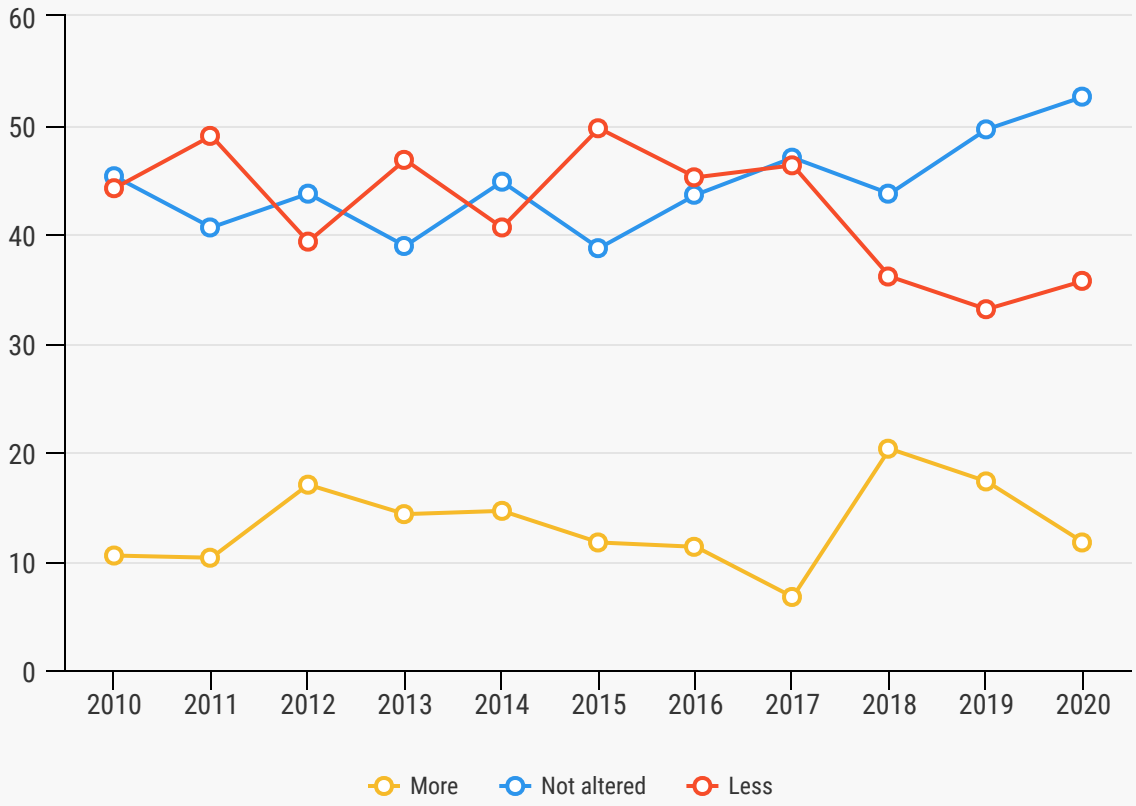


Q16 Over the last 12 months, what change has there been in the way clinical audit is resourced in your organisation?

33 respondents skipped this question, leaving n=154:

More resources available to support clinical audit	(18)	11.7%
Resources for clinical audit have not altered significantly	(81)	52,6%
Less resources available to support clinical audit	(55)	35.7%

As noted previously, one of the main reasons for setting up this survey in 2010 was to attain measurable data in relation to the 'reinvigoration of local and national clinical audit'.



The graph above identifies a number of trends. First of all, it is clear that ever since we set up the survey in 2010, only a small proportion of respondents report an increase in resources for clinical audit. Results for both 2018 and 2019 did report a small upturn in resourcing compared to previous years but 2020 data shows a fall back to pre-2017/18 results. Less than one in eight respondents in 2020 stated that their resources have increased in the last 12 months. Those marking their response 'resources for audit have not altered significantly' reached a peak of 52.6% in 2020, a result higher than at any point since this poll commenced in 2010.

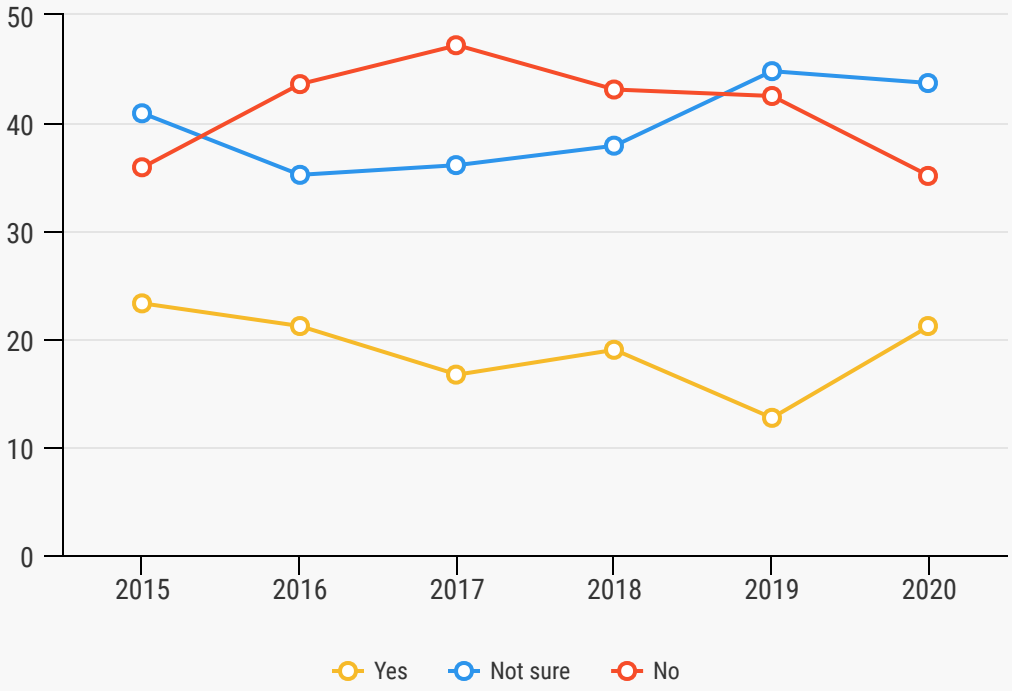
Q17 Ten years ago Sir Liam Donaldson stated that both national and local clinical audit needed to be reinvigorated. From a personal perspective do you think this objective has been achieved?

For national clinical audit:

36 respondents did not answer this part of Q17a, leaving a total of n=151:

Yes, reinvigorated	(32)	21.2%
Not sure	(66)	43.7%
No, not reinvigorated	(53)	35.1%

This question was first introduced into the survey in 2015 as this marked the tenth anniversary of Sir Liam Donaldson's call to 'reinvigorate' clinical audit. The graph below illustrates the results for the last five surveys from 2015 to 2020:



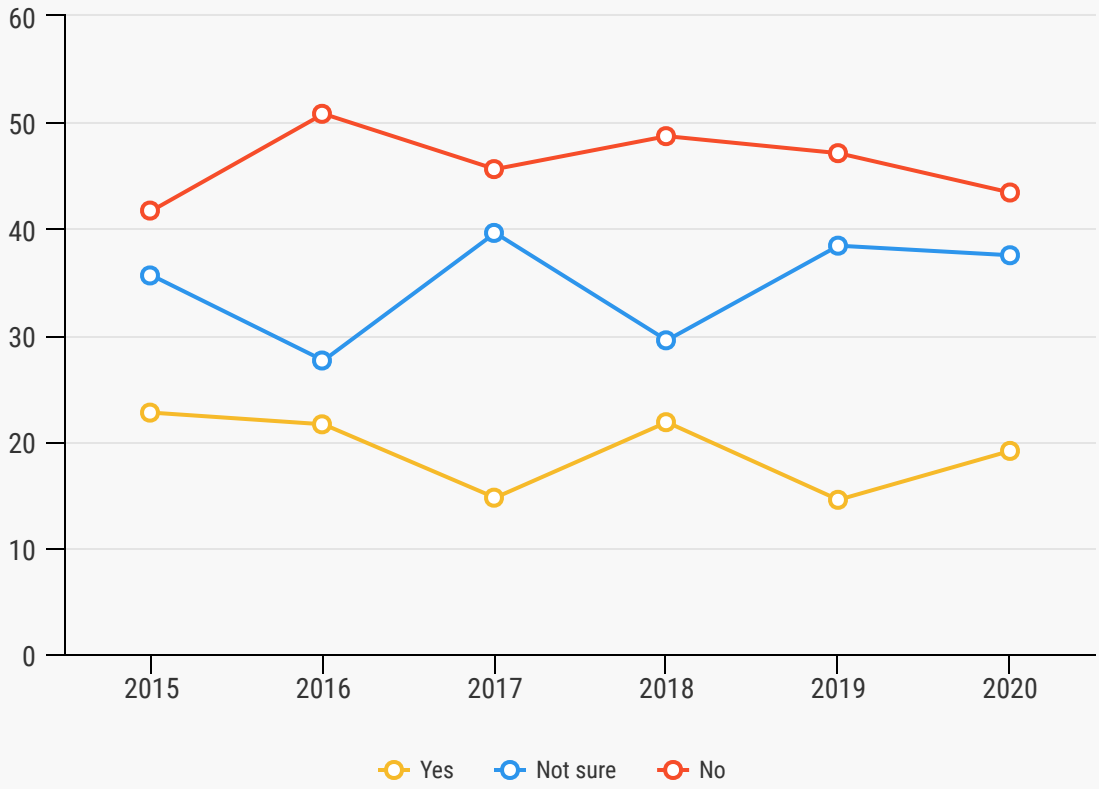
Results show a considerable level of consistency, although we accept that six surveys over five years represents a much smaller data-set compared to other questions in this survey. What is very noticeable in the data for 2020 is that the results are very similar to the data collected in 2015 (the first time we included this question in our survey).

Q18 Ten years ago Sir Liam Donaldson stated that both national and local clinical audit needed to be reinvigorated. From a personal perspective do you think this objective has been achieved?

For local clinical audit:
35 respondents did not answer this part of Q17b, leaving a total of n=152:

Yes, reinvigorated	(29)	19.1%
Not sure	(57)	37.5%
No, not reinvigorated	(66)	43.4%

This question was first introduced into the survey in 2015 as this marked the tenth anniversary of Sir Liam Donaldson's call to 'reinvigorate' clinical audit. The graph below illustrates the results for the last six surveys from 2015 to 2020:



Results show a considerable level of consistency, although we again point out that six surveys over five years represents a much smaller data-set compared to other questions in this survey. As per the results for reinvigoration of national clinical audit, the data for 2020 is remarkably similar to the results attained when this question was first asked in 2015.

Q19 Do you have any additional comments you would like to make in relation to the reinvigoration of clinical audit?

See pages 35 to 39 of this report for free-text comments in relation to this question.

Section 3: Conclusions and limitations

The Clinical Audit Support Centre (CASC) would like to pay thanks to:

1) All those who took time to complete the online survey (and any previous CASC annual surveys)
2) All those organisations such as: National Quality Improvement (including Clinical Audit) Network (N-QI-CAN) and regional clinical audit networks who helped to promote the survey.

The CASC Directors, consider that the results of this survey provide a highly accurate picture of the state of clinical audit in the UK at the time when the data was collected (November and December 2020). We acknowledge that there are some limitations and the response rate could be higher, but for eleven consecutive surveys running over ten years, we have received over 100 returns.

This final report builds on the headline results shared via the CASC e-Newsletter and Twitter account in January 2021. In addition to this 40-page report we have created a number of colourful one-page infographics that help highlight some of results and key themes that have emerged from our eleventh annual survey.

We are also pleased to include all comments (as submitted) in the appendix section. Although the CASC Team undertake the work involved in running this survey, we view the data collected as the property of the clinical audit and quality improvement community and to ensure complete transparency we have in effect shared all data that was submitted to us in 2020.

CASC conflicts of interest

We consider that CASC have no conflicts of interest in relation to this survey. CASC are not involved in any of the national clinical audits and we receive no central funding from NHS England, HQIP, NQICAN or any similar national body.

Next steps and future plans

As in previous years, CASC will endeavour to share the findings of this survey as widely as possible. We have already presented the results at a CASC Learn at Lunch session which attracted over 100 attendees.

We will also send this report to key bodies tasked and funded to improve clinical audit: NHS England, HQIP, etc. We have generated lots of infographics and images relating to the survey that we have shared via Twitter. As you would expect, we will review the questions contained in the survey and assess if any changes are required. The survey will run for a twelfth time in November / December 2021.

Appendix section

How would you classify yourself?

- Admin with an interest in audit/quality improvement
- Audit and NICE Officer
- Clinical audit facilitator I am non clinical but oversee the Quality Accounts and review the national audit reports and add them to our electronic audit system
- Clinical Effectiveness Practitioner
- Commissioner with a responsibility for quality assurance
- Consultant in Elderly Medicine
- Data scientist in a project management team who used to work in clinical audit, and likes to keep up with things in that area
- Governance professional with a responsibility for quality
- Input clerk
- Joint QI and audit
- Quality and Clinical governance lead clinician with a responsibility for overseeing audit
- Quality manager with audit responsibility
- Registered Clinical Informaticist with interest / responsibility for audit.

NOTE: 16 respondents marked 'other' in the corresponding question, but only 13 gave a follow-up answer.

What sector do you work in?

- Acute & Community Services are now together as one Trust
- Acute, Community and Mental Health
- All health and social care services for the population of the area served
- Children's community health
- Clinical Commissioning Group
- Community, Mental Health and Learning Disabilities
- Emergency Medicine
- Foundation Trust encompassing acute care (hospital) and community health
- Hospice (x2)
- Integrated acute and community (ICO)
- Intergrated Care Organisation
- NHS organisation
- Non NHS organization covering acute care, community and mental health
- Private
- Special Health Authority.

NOTE: 17 respondents marked 'other' in the corresponding question, but only 16 gave a follow-up answer.

What do you consider to be the most effective national clinical audit?

- Ambulance and Wales, so not part of national audits directly, but our work in Ambulance Quality Indicators in Wales nationally highlights key priorities for QI
- Audit of anti convulsant in children
- Benchmarking
- BTS Smoking Cessation
- Can't answer this as only have involvement in some of the national audits
- Can't say as only really involved in the medicine audits
- Cardiology national audits like MINAP
- Clear and concise without individuals going off on their own agenda
- COPD
- CQUINS
- Despite problems with the data, the National Parkinson's Audit has been effective in terms of engagement from clinicians and action planning
- Diabetes
- Direct impact on patient care and striving to improve the baseline of standard care
- EIP
- EOL
- Falls
- Falls and Fragility Fractures Audit programme
- Fracture Liaison Service - Database
- Glaucoma
- I actually don’t know an effective one! Although participation in the National Diabetes Footcare Audit has led to an effective business plan
- I have always been impressed with NACAP. They entwine clinical audit and other QI methodologies well and the database enables easy to access monitoring of current compliance
- I have only been involved in NCAP (National Clinical Audit of Psychosis)
- In my role I feel so called 'CA professional' are not necessarily professional auditor but rather audit coordinators trying to collate audit results/data from service lines, they do not always have a good grip of the audit requirement and just throw at you CQC or regulatory or Board or management requirements - it is therefore become a bureaucratic tick box exercises and create lots of pressures on the service line, my services have 200+ audits annually and I wonder if this is normal - how many are tick box and how many actually lead to improvement recognised by staff because they feel the benefit of doing such audit? Is there any robust evidence to support the current audit compliance approach that's is effective?
- MINAP
- NACAP
- NACAP, Lung Cancer
- NACEL (x2)
- Nat Ophthalmology Audit
- National Audit of Care at the End of Life
- National Audit of Inpatient Falls (NAIF) (x3)

What do you consider to be the most effective national clinical audit? (cont.)

- National Clinical Audit of Psychosis (x2)
- National Clinical Audit of Psychosis (NCAP)
- National Diabetes Audit (x2)
- National Diabetes Footcare Audit as our clinicians use the data to set audits and make improvements as required
- National Emergency Laparatomy Audit
- National Hip Fracture Database
- National intensive and Special Care (NNAP)
- National Neonatal Audit Programme
- NCAP
- NCAP (Psychosis)
- NCAP Early Interventions in Psychosis
- NCAP EIP
- NCAP seems to have the best focus
- NDFA
- NEIAA
- NELA (x10)
- NELA, SSI, SNAP, HF (NICOR)
- NHFD (x2)
- NJR
- NNAP
- None
- Not sure as very few applicable to community health and none of them have been very effective in my view
- NPDA
- OHCA
- OHCAO
- Paediatric diabetes
- Parkinson's UK: purely because our clinicians make a lot of changes due to this audit so I think its effective in our trust
- Personally none of them at present as they all need a shake up
- PICANet
- POMH (x5)
- POMH Sodium Valproate (x2)
- POMH-UK: any of them
- RCEM (x4)
- RCEM audits are respectable
- Royal College of Emergency Medicine
- Sadly as I work in primary care I cannot comment. Our sector is completely ignored by the NCAPOP
- SNAP and the ED audits
- SSNAP (x11)

What do you consider to be the most effective national clinical audit? (cont.)

- SSNAPP
- Stroke
- Stroke Audit and most RCEM audits
- TARN Audits
- The NACR
- UK Parkinson's Audit we took part in last year was really good due to their excellent communication through all stages (even about the next round) and my personal favourite was the individual reports about our contribution and learning actions/recommendation to take from that
- Uncertain
- Unsure
- Unsure in my sector.

What do you consider to be the least effective national clinical audit?

- All 'registries'
- All are effective
- All of them
- All of them are not effective just now
- Ambulance & Wales - not relevant
- Audit of peripheral vein cannulaton
- BAUS
- Benchmark
- Cataract
- Current rounds of National Clinical Audit of Psychosis
- Dementia
- Difficult to say as am only just learning about NCAs - registries are not particularly helpful when you cannot gain access to the results
- Early Inflammatory Arthritis (x2)
- Epilepsy 12
- Epilepsy 12 - there is no buy in for the audit from the regional clinical network
- Falls (x5)
- Falls - resulting in hip fracture. Small numbers for our type of trust
- Falls and Fragility
- Falls and Fragility Fractures Audit Programme (FFFAP), Fracture Liaison Service Database (FLS-DB)
- I can't really say
- IBD
- In terms of effort in and what we get back the Epilepsy 12 audit is not effective for us
- MBRRACE
- MINAP (x4)
- Most of the other NCAs other than the one I named in previous question, as there is lack of communication from main audit team I believe and sometimes it's difficult to see the affect our contribution has had in the audit and the specific actions/recommendations we should work on to improve our services as a Trust following the findings from the NCA
- NACEL (x2)
- NASH
- National Audit of Cardiac Rehab
- National Audit of Early Inflammatory Arthritis
- National Audit of Psychosis
- National audits are taking too long to publish so data analysis and actions are being completed before publication. This strains resources. National audits are carrying out re-audits before there is time to act on published results of previous audits. This is counterproductive as re-audits are not auditing whether improvements have been made. NCAPOP schedule needs a refresh. It had become outdated and should include more social care topics

What do you consider to be the least effective national clinical audit? (cont.)

- National Comparative Audit of Blood Transfusion - in particular Maternal Anaemia
- National Diabetes Foot Audit (NDFA)
- National Diabetes Footcare Audit
- National diabetes in pregnancy audit
- National Joint Registry
- National Vascular Registry
- NBoCA - linking of data and authenticity
- NBOCAP - National Bowel Cancer - half of our data wasn't included for some reason
- NCAP (x5)
- NCAP EI spotlight
- NCAs that have reporting lag and therefore cannot reflect current practice/ improvements in real time
- NCEPOD
- NCISH
- NDA (x2)
- NEIAA (x2)
- NICOR - Old data collection methods, tempremental, 3 years behind in reports, out dated questions, data set doesn't match proforma in some cases
- No view
- Non-Diabetic Hyperglycaemia, 2018-19 Diabetes Prevention Programme due to delay in publishing findings
- None (x2)
- Not sure (x4)
- Not sure these days but formerly NCAP
- NPDA
- Only as affective as how well they are set up, analysed and results used
- POMH (x2)
- Pregnancy in Diabetes
- PROMS
- Psychosis (x2)
- Reports published so long after the data period
- SAMBA (2)
- Smoking Cessation: as I don't think it has yet effected the care we deliver
- SSNAP (x2)
- The cardiology ones
- The NAIF
- Timely reporting
- Uncertain
- We currently only take part in 2 so this question isn't applicable.

What is the single best attribute of national clinical audits?

- A collaboration of sharing performances and learning from them
- A good source to benchmark against other Trust in order to identify best practice which could be shared with all Trusts for consideration to improve patient safety and continue to provide safe high quality care
- Ability to benchmark between services
- Ability to benchmark in some cases
- Ability to benchmark performance / care / services
- Ability to benchmark practice
- Access to timely, meaningful, data at a level of granularity (site-level) that can be used by the clinical teams to drive real improvements in patient care. Access to peer data to identify good practice elsewhere that can be learnt from
- Adds weight to a Business Case, e.g. we need to have an xxx specialist nurse as the national audit results will not improve otherwise
- All the preparation, analysis and report writing is done for you. However, not all NCAs produce Trust level reports which is not helpful
- As they are national they give a benchmark
- Availability of national comparative data offering meaningful benchmarking
- Being able to benchmark against similar trusts
- Being benchmarked with other Trusts
- Benchmarking - to give impetus to change and natural / health competition to improve care for patients
- Benchmark
- Benchmarking (x11 comments)
- Benchmarking across organisations
- Benchmarking against local / regional / national Trusts
- Benchmarking against other trusts
- Benchmarking against other trusts in the same specialty
- Benchmarking as long as this doesn't over burden the provider with collecting data variables
- Benchmarking care
- Benchmarking outcomes
- Benchmarking slides
- Benchmarking the Trust
- Benchmarking tools
- Board listen to the results and help with change as a result of the audit
- Can give evidence to support need for improvement
- Can’t think of any
- Collaboration
- Comparison between other Trusts
- Comparison can be completed nationally
- Comparison of performance - enables you to identify who is performing well and set up links to share best practice
- Consistency of tools allows a degree of benchmarking

What is the single best attribute of national clinical audits? (cont.)

- Directory and contacts
- Driving improvement
- Follow the principles of laying out the report in the same way we expect of local audits, all well and good having fancy infographics. But why is still so hard to find the standard that is being measured? Still too many national audits are not true audits but evaluation and benchmarking projects circumventing NHS R&D departments
- Forces our organisation to actually take part
- Getting the national picture
- Gives an insight into the bigger picture
- Good to benchmark against other areas in some ways as long as there is understanding that the set up of teams and how they work will have variation
- Great benchmarking opportunity
- Has supported my ability to influence staffing levels
- High profile, supports clinical and managerial buy in especially where linked to accreditation / BPT
- Holding services to account to obtain best practice for patients
- Identifying areas of concern
- Implementing changes to improve practice
- Improving care
- Improving patient care across the country together
- It is good to see the difference between what you have scored and the national results. This gives a good indication as to how well your trust is performing with clear improvements and actions advised
- Its enforcement is stricter
- Keeping standards high
- Large scale data collection allowing national comparison and identification of outlier hospitals
- Live results available online so actions can address any low compliance
- Mandatory
- Measuring yourself against a national average
- National benchmarking
- National benchmarking: sometimes being at the low end can get the board / commissioners onboard for changes such as financial
- National comparison
- National data collection and benchmarking. Sharing of good practice/learning
- National learning
- National methodology
- National oversight of performance against standards across the country
- National picture
- National promotion when Trust has excellent results
- Nationally collected data can make a difference
- Nationally created tools

What is the single best attribute of national clinical audits? (cont.)

- Overall learning and also seeing what / how well other Trusts with similar services are doing.
- Providing comparable data on trusts performance / outcomes
- Public availability of results
- Raising the profile of audit as a suitable methodology for QI
- Really clear and evidence based standards
- Report generated
- Rigour
- Shared learning and practice
- Sharing information and learning from others
- Simple clear standards
- Standardisation
- Standardisation of clinical outcomes
- Structured
- Supporting patient outcomes
- The ability to benchmark and demonstrate that others are doing it better, and therefore we can also
- The ability to benchmark / learn from other Trusts
- The ability to collaborate across regions / country to review practice
- The ability to compare ourselves nationally
- The best attribute is the national learning points / recommendations. If trusts simply concentrate on their own performance indicators then they might as well be doing a local audit. They could potentially miss key messaging which could help improve patient care / safety
- The best thing is the outcomes / recommendations for service improvement especially when they are applied by the majority of the trusts taking part
- The ease of use
- The introduction of service level spotlight audits
- They allow for a consistent national approach to audit which enables us to compare our performance against other similar organisations with ease
- They help us understand how widespread, or not, our difficulties are
- To improve patient care and outcomes
- To keep trusts and staff aware of local and national guidelines / standards of care, showing how each trust or national is doing
- To receive local stats
- Universal approach nationally
- Value of data and benchmarking nationally
- We can benchmark against other trusts
- When a round ends
- When done well they provide you with the opportunity to benchmark against other organisations and share learning
- You learn something new every time.

What one change would you make to improve national clinical audits?

- A move away from continuous data collection - all audits should have the same robust methodology and the amount of compulsory audits per Trust limited and prioritised
- All are required to provide real-time analysis, where performance indicators are updated when new data is added - allowing clinical teams to act in a more timely manner where variance occurs
- Be suitable for all organisations not just the acute
- Benchmarking slides more timely
- Better communication of why we need them. Some educational sessions on how to best conduct them
- Better engagement before during and after
- Better publication of data figures
- Breaks in the continuous data collection
- Broaden the spread of NCAs. Hospitals and medics have a current monopoly over NCAs
- Broaden their scope
- Clear standards that can be reported against
- Clear, and explicitly stated standards / criteria in a standardized format across national audits, something HQIP should has the power to stipulate when funding. HQIP is now a very different organisation. In my view HQIP's focus is now only National Audit Commissioning for self preservation and tokenism to the rest rather than quality improvement (no National audits do not always lead to quality improvements)
- Clearer reporting, objective, standards set (before the audit has collected data), target compliance, full cohort compliance and unit compliance
- Comparative data with peers
- Data linkage for other national pathway audit i.e. TARN for ambulance services, quarterly data lockdowns for MINAP, national sepsis audit (registry) - NEWS audits
- Data submission: in this day and age, there is no reason that the audit forms cannot be completed initially on line by the person completing the form. I have just inputted 400 forms for the NCAP EIP Re-audit and I was ready to go into a corner and cry
- Direct data extraction (where possible) to enable timelier reporting for the audits where this is not already possible
- Ease of contact with and through the audit body - it sometimes feels very difficult to have a conversation
- Ease of use towards communication/information of the national audit, i.e. data submission start date and deadline date / cohort range / proforma / online tool info / etc. Sometimes on national audits you need to log into the website to find all of this information and it is never in one place. Some an email form the program has certain information, but does not capture it all and it can be confusing. So a monthly / 2 monthly etc email to all registered trusts and staff who are registered receive all of this information in one email with updates etc, but keeping the email simple with data submission deadline, cohort range and other relevant information in the same email, but with new updates info also
- Easier data entry
- Easier to get to the data quickly
- Easy to use data input systems, that are easy to access, and not complex
- Engagement tools

What one change would you make to improve national clinical audits? (cont.)

- Ensure that they all have proper evidence based standards! I also need to include time lag in reporting is woefully inadequate
- Ensure that they follow an audit methodology and do not simply collect data for the research projects of those housed within the Royal Colleges
- Ensure that when the reports are published they are more accessible and not so hard to find with a clear link to where you can find trusts data where applicable. An email out to trusts with a link to the national report, as i find some audits I have to go hunting for at the end of the year as I have had no notification that the report has been published
- Ensure they have really well thought out and efficient online data input forms that are tested by people who know what they are doing
- Ensuring national reports are sent out timely so that data is not out of date
- Faster response time to results. It seems to take forever to come back with the last outcome!
- Fewer of them
- Forums to discuss and share learning - successful implementation of identified actions
- Guide trusts in their improvement work as a result of national audit data collection
- Have a maximum number of cycles - once an audit has been run a few times it ceases to be quality improvement and becomes a performance / assurance measure. Also it means that new audits can't be introduced because the existing ones are just run over and over again
- I am still learning
- I think the £10,000 fee is unfair on a community organisation when we are involved in so few and even if we are signed up we may not have any patients in that year who meet the criteria so we have no data to contribute
- Improve reporting timeframes
- Improve the MDT involvement - from the MDT being involved in the actual audit / data collection and then ensuring that the results and improvements become every body's business, including patients / families
- Improved communication networks between groups
- Include community health in the initial design. Care is moving from hospitals to the community but this isn't reflected in audit
- Increase the turnaround times from need for audit to feedback of results
- Individual Trust reports (e.g. Cardiac Rehab audit - how well is our service doing compared to other Trusts and key learning actions or recommendations we should work on) because sometimes it's hard to identify from the current annual reports about the affects of our contribution for the audit or recommendations specific to us
- Information on the websites needs to be more accessible and easy to find and standardised across National bodies
- Introduce UK wide, and include pre-hospital care
- Involve front line clinical audit staff in the design of the projects and take on board what they say
- Lag between data submission and finalised reports
- Less 'one off' big data collection and more smaller continuous
- Less onerous data collection
- Less onerous data collection with some of the audits being carried out on alternate years rather than every year
- Less woolly recommendations - give proper direction to trusts for improvements

What one change would you make to improve national clinical audits? (cont.)

- Lessen the burden of continuous audits
- Linking ambulance timescales to acute timescales
- Make all results easily available to clinical audit / QI teams within care settings. We have more capacity to highlight areas of poor compliance and drive improvement but we can only do this if we are able to have view of the results in the first place. This can prove very difficult so a central repository which includes local results (not just the national overview) where all results could be stored and easily obtained would be a real help
- Make NCAs much more bespoke and specific
- Make sure they are true clinical audits and not just a registry for collecting information about a certain patient group without any reference to standards
- Make the hospital chief exec. respond to each report saying what his / her trust are doing to improve
- Make the process simpler. For example there is an Age Related Macular Degeneration national audit but there is not fixed set of questions to be answered. Instead there is a huge number of possible questions that any particular hospital can choose from
- Make the reports clearer especially in being able to discern how subsamples have been identified
- Make them comply with the definition of a clinical audit
- Make them follow an audit methodology
- Make them more accessible with all information available
- Manual input from paper copies
- Maybe more interactive with the results so we can compare and learn easier
- Medics should do their data collection in a timely fashion
- More community Trust-focused national audits
- More direct communication from the audit provider to identify us / our services to undertake the audit
- More equitable and inclusive distribution of NCAs. Do NHS England not realise that care of patients does actually take place outside of hospitals? Shambolic
- More frequent reporting
- More in the community settings
- More influence over the questions that are included, some really don't seem relevant or collating data for interest rather than audit
- More involvement of local clinical audit professionals in their planning
- More real time, quick reports so learning and changes can happen at the time
- More registries
- More standardised approach to Trust level data
- Much more uniform in terms of reports and internet sites
- National trust level accountability for improvements
- NCAPOP schedule needs a refresh. It had become outdated and should include more social care topics
- NCAs need to be re-designed to look at care across pathways. As it stands, all NCAs I have ever seen look at one part of a patient's care within a specific care setting. How does this inform our understanding of the 'patient journey'

What one change would you make to improve national clinical audits? (cont.)

- Primary care are a forgotten sector in the NCAPOP, I'm sure that this will be the same for many other non-acute settings. provide linked guidance / regulation to individual audit - why frontline / clinical team need to do it - where is the requirement coming from? it helps us to challenge the status quo and better understand the essence of each requirements of each audit e.g. hand hygiene - who is the authority to say we must do HH audit and how many samples are to be audited? X% of the case load? 10 cases? 20 or 50 samples? Lots of muddled up by the time information filtered down to the frontline in large organisation
- Quicker publication of results, even if just results / figures issued in advance of fully narrated reports
- Quicker reporting. The best / most effective ones report quarterly, however even this is too slow sometimes TARN have made the right inroads in their new business analyst system, however I'm yet to see it used properly
- Quicker reports
- Quicker turn-around on audit reports
- Quicker turnaround for report. next cycle only to be started once previous report has been released so action plans can be put into practice
- Reduce frequency to make them more reactive rather collecting data for the sake of it
- Reduce the number of recommendations - less is more....
- Reporting times
- Reports sooner
- Results are slow to be sent back
- Return of results - particularly snapshot audits. Data that is over a year old becomes less meaningful
- Slow return of results / reporting. Shambolic delays at times
- Speed of reporting - always slow
- Speedier publication of national audit reports
- Standardisation in processes
- Talk about them more in the press
- The delay getting results - as they are often based on a slightly old sample anyway, it sometimes works out as giving us a picture of where we were 2 years ago
- The length of time between collecting the data and receiving the results- sometimes it is so long that the results are no longer relevant
- The length of time it takes to produce the reports
- The selection of national audits needs to be reviewed, aligned with the NHS priorities and targeted at the correct organisations
- The speed in which data / results is made available
- They should be linked together - there is a lot of duplication for data collectors. Often the same patients appearing on lists for different National Audits. If they could be linked, so that a patient appears once, and they are audited for everything in one, it would be much easier
- Timelier reports
- Timeliness of publication of results
- Timeliness of reporting.
- Timely release of National Reports
- Timely reporting. Access to everything you need on the website

What one change would you make to improve national clinical audits? (cont.)

- Timely results
- Timescales
- Turn around should be 3 months - no longer
- Uncertain
- Vision and Governance from the Annual report - to both clinical and non clinical team
- Certain culture issues - nationals around on transparency and open sharing of outcomes - not membership based
- We need a radical re-think of NCAs as they stand. The national 'programme' now looks tired. Where is the dynamism? Where are the new audits? When will the hospital domination of NCAs be challenged? HQIP don't seem to be interested in anything other than measuring acute care
- When performance data is pulled from a CCG area and not individual trusts, data is very meaningless for us.

Within your current organisation would you like more or less national clinical audits to be made available?

- "Made available" - presume this to mean do we wish to see more or less national clinical audit topics. Short answer: less. Less - most of them are terrible in terms on content, few set out the explicit standards to which a participant is compared against, without which we would not register a local audit! HQIP are not applying any of their own defined criteria to the 'new' national audits that get started and do not do it retrospectively to pre-existing topics, meaning we are forced to participate in poorly thought out audits. There are a number of important national audits, such as what was DAHNO that appear to have been dropped simply because no-one else would take them on. There are so many 'national audits' that are outside the remit of NCAPOP / quality accounts that are not really national clinical audit at all, but blatantly collecting data to then publish new knowledge on a subject (that tend include a letter from the Scottish NHS HRA confirming that is doesn't need ethics approval (which doesn't make it a clinical audit) and no-one seems to be policing it
- A few more but only if they are of good quality
- A lot of NCAs are just tick box exercises, they take up a lot of resource, yet there seems to be little improvement work. They are used for assurance purposes, and to confirm outlier status, but my general feeling is there is not a lot of positive action taken to improve, as compared to local audits. Something we are working on, but they do not seem to have the same impact as local clinician led projects
- Acute care seem to be over burdened with continuous data collection It would be nice to concentrate on a particular area and then move on to another area, once business as usual is established - respiratory seem to be one of the higher NCAPOP specialty to be hit
- Ambulance and Wales - would be UK wide pre-hospital care National Audits
- And with a greater focus on the quality improvement aspect - as well as sharing how other organisations have improved
- Any national audit that take up too much time and delivers nothing must be avoided. Any audits that are taking 1-2 years to write reports are not useful. Hospital should focus their resources on top 35 audits and do a good job rather than 50 done poorly
- As a mental health and learning disabilities Trust we are eligible for a small number of NCAs, it would be good to have some variety in this work. As a mental health trust, we do not have many applicable national clinical audits. The limited number of NCAs that we take part in have been effective in improving services and it would be beneficial to have more NCAs for mental health trusts
- As an acute Trust, we have over 50 on the Quality Accounts list, plus numerous college ones which aren't. The resources required to support these are becoming unmanageable and costly
- As we're a community Trust, we don't have that many NCAs to take part in and we think we can do more
- Audits throughout he country should be the same or similar so that comparisons can be made. I don't think more audits in total should be done but that the ones that are currently 'local' should share characteristics with the rest of the nation
- Better quality, fewer audits
- But only ones which provide worthwhile data, in a timely manner and are going to have positive changes from them
- Clinicians do not have time to undertake national clinical audits

Within your current organisation would you like more or less national clinical audits to be made available? (cont.)

- Considerable delay in getting report so data is quite 'old' by the time it is received. Clinicians either have moved on to something else, are not interested or do not want to do anything with 'old' data
- Currently there are small number of National Audits which are applicable to Community Trusts. There needs to be an engagement process with Community Trusts and stakeholders to ascertain topic areas for national audits that would be applicable to the majority or all Community Trusts to part take in
- During the suspension of the national audit plan we were able to focus more time and energy into locally driven projects that we wanted to work on rather than areas mandated to us
- Engagement is an issue, particularly in the 'audits' that are deemed 'less' useful. We would be better off having quality rather than quantity
- Even though we have few NCAs relevant to Mental Health I only want more NCAs if they are bespoke and high quality. My colleagues in hospitals tell me most NCAs are merely vast data collection trawls. No thank you
- Far too many national audits each year, would prefer more to move towards registries and continuous data collection. The days of having capacity to chase clinical leads have gone and national audits are time consuming and little is changed after participation
- Few are designed for community from the beginning but community is added rather ineffectively as an add on later
- Fewer audits with a focus on quality and easily measurable targets
- Fewer national audits would free up capacity to focus on more comprehensive clinical audit / quality improvement projects that are more relevant to us as an organisation
- For the type of trust I work in, particularly the specialities I support, there does not seem to be many applicable clinical audits - CAMHS, Learning Disabilities, community services such as health visiting, AHPs
- Generally there are enough NCA's and by adding more this would reduce the resource needed or available to address local issues or QIPs generally
- Good for benchmarking
- Great way to benchmark current performance in our Trust against national picture, great tool for reflection when comparing results against other Trusts
- Great way to compare and learn from other Trusts
- Happy if modelling is in place. Many nationals can be integrated to better service rather than duplicate the same data - make it effective of time and resource
- Happy with current level
- I feel we can really benefit from learning and sharing nationally and these audits help our Trust to do this.
- I have said more but only if these audits are set up with community services in mind as usually they are set up acute focussed and difficult for community organisations to fully get involved. Also the more would only apply if we can get more staff as at present it is not achievable to do more audit with the staff we have
- I think overall I'd prefer neither as I think the quality needs to increase rather than any other changes, however I do believe in clinical audits so out of the two: more
- I think we have a good balance for the small team that we are!
- I work in a hospital. We are over-run by national audits

Within your current organisation would you like more or less national clinical audits to be made available? (cont.)

- I work in Mental Health and there are only a handful of NCAs relevant to us
- I would prefer less volume but higher quality, we currently oversee approx. 37 and keeping a track of these is hugely time consuming. There is also repetition with the likes of GIRFT
- If you look at the definition of a Clinical Audit you will see that National Audits do not comply with this definition
- In a normal year we have 64 national audits. they range from excellent providing feedback either instantly RCEM, quarterly (NELA) meaning that we can act on relevant data and see change. then there are others that take 1-2 years to get back to us. I can not for love nor money get anyone interested in those results
- It's very difficult to find national audits that are actually relevant to our community services, even if initially they say that they are. Usually with further information they are not something we can take part in as we don't have the staffing capacity to commit to it
- Less because they require a lot of clinical and non-clinical support
- Less but more effective and more feedback at a local level
- Less but more focused audits I would feel would be more beneficial, in terms of the workload
- Maybe a little few more but not over exhaustive. When I say more, I mean a few more spotlight national audits where a certain standard or results is really poor and we focus more on this root cause analysis
- More - but then we don't have to resources to take part in them and clinician's don't have any time
- More if....they are: focused, have quick turnaround of results, additional resources and recognise when it is time to stop the over-arching audit and have a focus on particular elements that require improvement and share the learning
- More pre hospital audits would be beneficial to patient care standards
- Most are adult focussed with very little information for paediatrics
- Most national audits are set up for the acute sector. It would be good if there was more focus on community NHS trusts. I think the work of community trusts is not always recognised or acknowledged
- Most of our mental health audits are ran by POMH, which is not mandatory. These provide the most significant service improvements
- My organisation does not have a strong audit process
- National audits are really valuable, but the major caveat is that only applies if a) the turn around of results is speedy so that clinicians have belief that the results are reflective of practice, b) they cost of being part of the national audit isn't prohibitive (particularly dependant on how helpful the information they provide ultimately is) and c) the amount of effort that national audits take when there is no electronic means of providing regular information can be huge (and expensive if someone has had to be employed to find and upload this information)
- National audits provide a clear structure to clinical audit activity, setting out clear methodologies, provision of audit tools and in some cases real-time analysis (the good ones). They also allow for benchmarking and reduction of variance in practice. Data collection can be significant especially where no Electronic Patient Record is available, but this sets out a clear requirement for audit as with the current quality accounts / NCAPOP activity. National Audits tend to get more buy in from clinical leads and business managers

Within your current organisation would you like more or less national clinical audits to be made available? (cont.)

- Need to ensure that the current audits are reviewed and improvements made and then re-audited before we can take on anything else. Also need to ensure there is a more joined up approach to audit and get away from the medical model which is generally the approach
- Next years audit plan is a heavy burden and I worry about our capacity to do it all well
- Not adding any value and missing the key point of an Audit, They seem to have got worse in the organisation of them, put a lot of pressure on already stretched teams, the data input is never easy or simple, and the reports come out so late, you cannot implement the actions in a timely manner, hence missing the whole point of a audit
- Not more or less but the quality and impact of such audit
- Please spread strategically across the year
- Pressure on clinicians is already extremely high, and I do not believe they have the capacity for the work they do now. I think it also would dilute the value of the audits already carried out
- Reports take a long time to be published
- Royal College of Psychiatrists lost funding for its anxiety and depression programme this year and that leaves a big clinical area without national audit data
- Saves time designing measures and analyzing data, as long as data is available quickly
- So there can be more dedication and commitment to their delivery
- Some national audits are 'registries' or have 'multiple' questionnaires (more like surveys) making them challenging to manage / confusing for clinicians. Multiple reports produced usually 12 -18 months after the 'audit' activity is too long to wait
- Some of the data collection tools are dreadful e.g. IBD and very time consuming. We've lost a valuable member of clinical staff partly because of the data collection for a national audit. Some of the national audits just blither on about the same recommendations year after year - real practical advice on HOW to improve results would be appreciated along with the necessary investment
- Stay the same please
- The acute sector is saturated with national audits. It is also saturated in national audits within a small number of conditions i.e. cardiac and respiratory for example, which has a huge impact on often small clinical teams. Audits should not be undertaken within the acute sector as a method of accessing proxy data for primary care. The focus should be on improving public health across the pathway and auditing accordingly. More audits should be focused on improving the quality of care within the community, therefore improving patient care, experience and reducing hospitalisations
- The burden on staff collecting data is huge, results are not timely- often the next round of collection begins before or around the time that the results are published. This means to make improvements local audit teams need to analyse the results themselves which seems wasteful of resources
- The current cohort of NCAs is average at best. If high quality NCAs with minimal data burden and rapid reporting can be assured I would like more. But we have been asking for these changes for years but these request continue to fall on deaf ears

Within your current organisation would you like more or less national clinical audits to be made available? (cont.)

- The feedback from the national programme is slow, and more often than not we cannot analyse down to our own results
- The national audits don't really fit in the community setting, feel the time spent completing them is not worthwhile
- The ones we have in acute care are overwhelming us. We keep reporting this, but no one appears to be listening
- The only reason to state less audits is the amount of effort put in and the lack of engagement received. Despite promoting national work and pointing out the importance of these they aren't seen as a priority or important enough. They run to close together so you juggle more than one at a time and have to contact the same people about different projects and data
- The pressure on Acute hospitals is immense and growing, when there are 50+ projects to participate in with many being continuous data collection and some of them requiring large number of submissions to ensure participation rates are high this causes more pressure and less time to implement robust changes
- The spotlight audits have proven to be more successful than the more generalised core audit but there have only been two of these in recent years (NCAP EIP - still running and NCAAD - Psychological Therapies - no longer on programme)
- The workload for NCAs is staggeringly high as it stands. Why would we want more?
- There are a lot of them and sometime they are over whelming the clinicians who has to collect the data. Also some of these you do the work and then it is difficult to get the report and individual results unless you go hunting for them and then sometimes it is still impossible to find them
- There are a number of national audits that are continual data collections. Some of the reports take a while to come through with little or no comparable local data. When changes are made it is often up to 2 years before this is reflected in national results due to this time lag. We need fewer more focused audits with quicker turnaround times or access to local data so that clinicians can see the real time benefits of some of these time consuming audits. Some of the data collected is also duplicated between audits so clinicians feel they are collecting the same information which can appear rather pointless to them. Make participation in national audits more beneficial for the clinicians
- There are very few in Mental Health Trusts
- There must be more audits to do for improvement
- There seems to be a shift towards accreditation now
- They are time consuming and it is difficult to get staff to engage
- This is a qualified answer in that I would only like to see more audits for my healthcare sector and Trust if they are truly audits. My concern as a clinician remains that we become embroiled in the mass data gathering exercise that acute trusts must endure
- This is difficult to answer as although more national audits would be good in generating support and participation, the resources in clinical audit won't expand with it, so it would still be the same - fighting fires and trying to keep one step ahead
- Though more means more undertaking, I am not sure all breadths of medical topics are covered that could use more supports such as chronic medical topics

Within your current organisation would you like more or less national clinical audits to be made available? (cont.)

- Time consuming, lacks local ownership and modification. Comparing trusts may not be always appropriate due to local needs, Not always linked with GIRFT
- Too many already for hospitals
- Too many NCAs have an acute focus - more patient pathway audits needed across providers
- Trusts should be exploring the option of replacing out of date, irrelevant NCA's with more pertinent local interests
- Unless data is collected nationally, it will not be effective. There are a number of audits that need to take place nationally and every Trust need to understand and take part
- We are a large acute Trust, with a small audit team that is stretched very thin over the specialities. Fewer national audits would free us up to concentrate more on local improvement work
- We are overloaded with National audit data collection that is too time-consuming for clinicians - we support all aspects of data collection, auditing, data entry. With very little support back
- We don't have many national audits in the mental health sector and they have a high profile due to the ability to benchmark between Trusts so a few more would be welcomed but with some definite caveats, e.g. audit not assurance, clinical audit professionals involved in development, quality control of audit design and reporting
- We effectively have no national audits relevant and specific to our sector. This is disappointing as I had high hopes when HQIP took over the programme back in 2008. Sadly they haven't delivered for the primary care sector and don't seem to have any understanding of the healthcare provision and QI work we undertake. A sad state of affairs. Having seen that acute trusts have many national projects that have a heavy emphasis on collecting many data variables I would only want high quality projects that pinpoint QI goals
- We need less of these projects, most are data collection exercises and do not follow an audit methodology. The projects are paid for by our Trust and NEVER lead to improvement, the results take so long to be published that we have moved to other priorities. Where we believe there is an issue in relation to a condition covered by the NCAPOP we audit at a local level and use these results to inform a change in practice
- We need to ensure that there is still capacity to do the important local priority audits
- When we get quarterly or yearly results then any actions feel appropriate. When the results cover data that was over two or three years ago then things have moved on since then and any actions feel out of touch
- Would be nice for organisations to be able to focus on local audits rather than resource mandatory national audits which are limited.

Do you have any additional comments you would like to add in relation to the reinvigoration of clinical audit?

- Audit is seen as 'old hat' and confused by the move to call audits QI projects - which they are - but can QI and Clinical Audit be seen as options to choose from when attempting to improve services / outcomes
- Audit staff need a professional standard for their work to be identified fully. We are seeing this QI and audit team merging together. However the job descriptions are banded differently with more senior roles and higher banding being seen in QI roles. If recognition is not paid to the audit role it will still have found insignificant in organizations
- Budget and resources for Clinical Audit is going down year on year. There is a complete lack of leadership involvement and support. There is no interest and opportunities for development. All resources are being diverted to QI. We have a team of QI being given 10 times more budget with a team of 10 / 12 people starting at Band 7 and 8 whereas in the clinical audit team there is only 3 staff at Band 5 with no admin support
- Can we please scrap HQIP?
- Clinical audit is being reinvigorated in that it is being encompassed within quality improvement as a whole. When people see that it is a quality improvement method and choose to use it when it is appropriate and in line with other QI methods this may lead to better outcomes
- Clinical audit needs to be seen as a valuable QI methodology. I think NHS England needs to invest more into NCAPOP as it comes across as significantly underfunded
- Clinical audit will not be reinvigorated unless it is recognised, supported and resourced as a methodology for Quality Improvement. As long as the Model for Health Improvement (PDSA) is being touted as the all encompassing methodology for quality improvement, Clinical Audit will continue to be under-funded, under-rated, under resourced and a poor relation
- COVID 19 has posed an additional challenge in the way that we engage with our patients. For some services audit has not been a priority, but rather shorter QI programs. clinical audit needs to be further reinvigorated
- Covid-19 has made engagement very difficult, and will continue to do so. Well run local audit would be so valuable in hospital - but these is not the time or appetite for full scale cycles
- Current focus on quality improvement
- For someone who works in NHS, I'd like some resources to be invested in creating on our own software system that would allow us to monitor and manage clinical audits as well as implementation of guidelines / Trust policies, which would mean we would not have to rely on or pay for licences/training for external softwares - this would then free up some of that funding and resources for other things for quality improvement
- From my own perspective, in an ambulance trust, I think the effectiveness of clinical audit is undermined by the low level of involvement of frontline clinicians (& patients) which is a challenge for us
- Has been a very difficult year given the pandemic and very stretched clinicians who have less and less time to focus on audit activity - many services are just about managing to function day to day, let alone considering undertaking audit, really think this needs to be taken into account
- HQIP need to be reinvigorated, the organisation is rather tired and seems to only understand and support acute trust care
- I don't think it is seen as important enough

Do you have any additional comments you would like to add in relation to the reinvigoration of clinical audit? (cont.)

- I feel it is important to give support to all clinical audit activity across a whole organisation but in my trust the small quick clinical audits do not seem to be given enough allocated resources to ensure they are effective. Emphasis is very much on 'must do' 'should do' and national audits and staff doing small clinical audit projects who need some advice and help find it difficult to get that
- I feel that there has been less and less 'interest' in audit and the processes. Where there has been a focus, it seems to have been on the quantity of audits carried out rather than the quality and the changes made as a result
- I think clinical audit is seen as a poor relation to the Model for Improvement and the focus is on the assurance component of clinical audit, ignoring the improvement component
- I think local or national audit depends on what you try to achieve, totally context dependent, the Q is too generic
- I think that it would help for both: national and local audits to have report template structured in the same way, e.g.: summary of statistics / recommendations to be placed at the beginning or end of report, also to encourage for this data to be recorded (not every report / audit had the summary of findings added / published.) Being able to see differences over the time is very important. And finding them easily would be a great improvement
- I think the national push for quality improvement has made people think less of clinical audit and that clinical audit is something different that quality improvement. I've had people say to me but audit isn't improvement it's just counting!
- I think the re-branding of Audit being a Quality Improvement tool and the support of the new methodologies has helped people reengage with audit yes but National Audit still seems to be one we have to chase when it comes to collating our output, even when we are achieving high standards. We need to celebrate this more!
- I think there is still the misconception that clinical audit has been 'done' if some data has been collected and it's been presented. The QI mindset at least drives the improvement element (though has its own difficulties with people implementing a single 'solution' and thinking that's sufficient.... Both CA and QI are much more complex and time consuming than first meets the eye which clinicians simply don't have time for
- Impact of Covid
- In my opinion we need to align clinical audit and QI more effectively. My Trust have a QI team (all paid Band 7s) while my audit team are all paid less. We do much the same work, although that of the audit team is much more structured. It is ironic that our QI team talk constantly about LEAN, streamlining, collaboration, etc. when the system we have in place for measuring and improving care is so inefficient and dis-jointed. Frankly, I have come to the conclusion that most QI projects our Trust do are nebulous excuses for testing whacky ideas and dossing about
- In our Trust, we have a new team focussing on QI, which means that the clinical audit team can better support pure CA projects, where standards can be measured
- In some ways this objective was achieved, but has become more transparent since the rise of quality improvement, where audit is seen as a separate process and not a QI methodology. This seems to have come full circle with national audit providing the basis for QI activity, but in the interim clinical audit teams were not significantly resourced or thought of as part of the improvement process
- Integrate and support services for care provided
- It can be seen as a tick box exercise and not as meaningful as say the wider QI methodologies

Do you have any additional comments you would like to add in relation to the reinvigoration of clinical audit? (cont.)

- It feels like the local audit community have little opportunity to change the current status quo. This perceived lack of inability to influence is perpetuated by a lack of credible representation in a national level meaning the challenge to HQIP is toothless
- It hasn't modernised, and as a consequence data driven quality Indicators and dashboards are being used by organisations and departments as they are so current
- It is always the same suppliers with their own agendas so not likely to be invigorated
- It is the domain of medical staff and while it is the mystery surrounding it will not ensure audit and the improvement in patient care / outcomes will not improve as it should
- It still is extremely challenging to involve staff in clinical audits and make them understand how easy it may be and how helpful once fully embed on their daily work. I believe we need to motivate health professionals to audit as a QI process at a very early stage while during their academic training to become doctors, nurses, OT's, etc. They need to be involved in audit projects, to observe how audit teams work, how this leads to improvement on a short-to-long term basis, before they start seeing it as extra work and a burden
- It's nice to see people focussing on 'QI' - however it's frustrating that a lot of people on that buzzword bandwagon see it as QI vs Audit. Where I think most people I know who like audit already see this as a quality improvement methodology and have been doing that for years, not just because suddenly it's got a fancy name
- Local audit has been superseded by QI project
- Local clinical audit has been eclipsed by QI and is rarely used to improve practice in my Trust
- Local clinical audit has not been reinvigorated as such but in recent years the promotion of clinical audit has seemed to help the merger with other QI methods to be more on an even footing and less of a takeover than it threatened to be
- More senior involvement and an escalation system is required to put clinical audit on the map. If an escalation system was put in place, more audits would be done, i.e. it is mandatory to participate in all audits if your trust has this service, including local audits
- National Audit will become more and more useful, but its happening at the expense of local audit support, meaning but the time you get the national audit results, it's too out of date, and the timely benefits of local audits. It like building a road to a destinations, with too little tarmac, and when you run out you lifting the tarmac from the start of the road, but still exiting the road to work. No attention is being paid to how local audit staff are now even more deskilled than in 2007 due to being turn in to National audit Facilitators, rather than Clinical Audit Facilitator supporting local staff in local audits. This is a big loss that I believe will impact negatively on patients safety in the coming years, as we have less and less AHP, Nurse or doctors taking part in local audits, and only seeing dat-collection that goes into a diluted out of date national audit report, that's too easy to ignore because it too easy to remove yourself from the national data. The priority for national audits should be local data reports first with how you compare to the national picture. Some do this, but it needs to be standards across all. To improve patients care and outcomes, it's the local data that is needed in a timely manner. National reports first serves the author's CVs, and academia first and the patient last. Good clinical audit is not about academia, it's about acting on timely information. National audits are not timely, and impact on local audits to have less and less local timely information to act on

Do you have any additional comments you would like to add in relation to the reinvigoration of clinical audit? (cont.)

- National Audits could be amazing and do amazing things and some are great. the ones that aren't need to end, and not in the future, but soon
- Needs a relaunch with QI
- Needs proper investment in the culture of the NHS - it is a powerful tool for change but is not used as that - and integrate with quality improvement
- NQICAN are a disgrace
- NQICAN now feel part of HQIP to me. And that is not a compliment
- Our department is currently under change where the department is moving to effectiveness, we will still facilitate audits but also cover NICE guidance, NPSA, HSIB etc. by linking all areas of effectiveness it is felt that as a department we can help improvement patient care more efficiently. We have been told to involve or risk our audit roles becoming extinct
- Our trust started using the Safeguard audit module of Ulysses in 2017. Since that time there has been a vast improvement in the way we are able to monitor the completion of audit reports and their subsequent actions. Safeguard automatically sends weekly email reminders to auditors as soon as their audits and/or actions become overdue which helps us to reduce the number of overdue audits on our database. Safeguard also requires auditors to report on the learning they have identified as a result of each completed audit. I am very impressed with this system and would recommend it to other trusts
- QIP's have superseded audit in popularity, audit is still seen as old fashioned and 'clunky'. We have tried locally to push short, quick audits however we haven't had the direction from senior management or the resource to push it further
- Quality improvement seems to be the buzz of the moment, with Clinical Audit seen as only one of the tools you can use. Reinvigoration is difficult here - there is an apathy in the team, particularly in the Team Leader. We don't even participate in the Clinical Audit Week
- Some national audits are definitely improved. Results are available quarterly via a dashboard. Some appear to report inaccurate data, particularly the cancer ones
- Thank you CASC for running this over the last 10 years. Invaluable stuff!
- That it needs supporting and promoting from senior leaders
- The priority for clinicians and audit has not changed
- The profile has been raised but we are some way from it getting the attention it needs to consistently drive change
- The push towards Quality Improvement, has in my opinion, devalued the skills of a Clinical Auditor. The publicity, funding and general push is towards the QI approach and this has made Audit teams feel very devalued , demotivated and demoralised. Clinical Audit seems to have become the second rate choice, and Trust Boards have gone with the QI approach, not Clinical Audit
- The removal of funding from HQIP to support the reinvigoration of local audit clearly demonstrates that this is not seen as a national priority by NHS England
- The value of Clinical audit has decreased significantly in the last few years. Young clinicians no longer want to be involved as they want to do “QIPs” and cannot see the value in audit - until assurance is required. For audit teams it has been demoralising

Do you have any additional comments you would like to add in relation to the reinvigoration of clinical audit? (cont.)

- There is a clear improvement in the Audit Department and its engagement with clinicians in the last year. There are many projects to promote audit in my Trust
- There is no doubt that covid has had a huge detrimental impact upon clinical audit this year: we have had to prioritise resources away from clinical audit and have not been able to involve patients and families as we had intended
- There is so much variation between Trusts in terms of what audit departments do and don't do. In our Trust the audit department is responsible for facilitating the CQUIN programme which takes up a lot of time and energy, so the suspension of this for 20-21 has freed up a lot of our capacity to enable us to do more traditional audit work. QI is very much the shiny new toy and there is little recognition of audit as a QI tool which is very frustrating
- This is a long while ago - not sure why you are asking this question
- This quote is from 2007 - since then there has definitely been an invigoration in both these areas
- To improve clinical audit we further commitment from Senior Management and a change in culture relating to audit so that audit is at the front of what clinicians do. Also we need further support from the GMC in relation to participating in clinical audit
- Trusts need to invest more resources into clinical audit to provide assurances and evidence of improvement of patient safety and quality i.e. yearly showcase events, electronic system to monitor audits, etc
- We need to look at reinvigoration of the national programme again, it is tired and unresponsive to clinician need. Data turn around is far too cumbersome in my experience, these projects and the organisations responsible for them need to move with the times
- We're just low priority until something goes wrong - clinicians in general see clinical audit as a chore to be avoided
- When we make it about improving care clinicians are much more likely to get involved. They do not like to think that it's just data collection - it's important that they see what the end point is and what will be done with the data that is collected
- Where are NHS England? I've not heard any of their leaders talk about clinical audit for years
- Where was everything that HQIP promised to deliver on local audit when they got the contract
- Where you get good clinician involvement you get good results and actions etc. But unfortunately clinicians are not always given the time to be able to support clinical audits in the organisations as much as they should be
- With the current staffing levels it is difficult to support clinical interest audits from staff apart from advice only. This is very unfortunate as we need to nurture clinicians interest in doing clinical audit
- Within our trust we are now strengthening the implementation of the action / quality improvements to demonstrate the real benefits brought by clinical audits. Moving away from "doing a clinical audit project" just for education purposes
- Without clinicians who champion and support clinical audit, CA staff don't stand a chance. The focus at the moment if a QI work, so many don't understand that if done carried out correctly CA is QI!

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