Clinical Audit Today
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## In this issue



# Editorial: It's raining men, hallelujah?

**Stephen Ashmore**
*Director,*
*Clinical Audit Support Centre*
*Editor, Clinical Audit Today*

This is probably going to sound like quite an odd point for me to make as a man, but has anyone noticed that virtually all the current senior roles and positions of importance in clinical audit are held by men? This fact didn't dawn on me until I recently started writing my regular news article for this journal. I was looking at HQIP, NCAAG and NAGG, etc… then all of a sudden the penny dropped! All three organisations are headed by men and males hold key positions in each organisation. NCAAG do have a number of females on their secretariat, but Professor Nick Black and Martin Ferris are the main players. NAGG have an even more interesting set up…. according to their website NAGG have 27 current members, 21 of whom are female!! Yet, 3 of the 4 senior positions within the group (including Chair Robin Sasaru and Chris Swonnell as General Secretary) are held by men and 9 years since the group was established we still await their first female chair. HQIP are led by CEO Robin Burgess, Paul Lelliott heads their board of predominantly male directors and Darren Thorne leads the LQIT. And it doesn't stop there… Mr David Gilbert heads up clinical audit at the Department of Health and when I requested suggestions for a possible keynote speaker to talk about the reinvigoration of audit at our forthcoming national audit event the names DH suggested were Roger Boyle, Martin Hensher, Dominic Hardy and Bruce Keogh. For those of you used to analysing complex audit data, I am sure you might be able to spot what you would call a "significant trend".

Now don't get me wrong, I have nothing against anyone I have mentioned, but what I find baffling is that the experience Tracy and I have working in audit at the coalface up and down the country is that women not men, often lead the way! The majority of local audit teams are headed by highly skilled and professional women and when we ran our first audit poster competition at the 2008 conference all three prizes were won by female entrants. Interestingly, the vast majority of those attending our accredited training courses are female and they have a better success rate at gaining the relevant qualifications than men who come on our courses!

It is almost as though we have a pool of women managing audit teams and doing great work, but then a glass ceiling that prevents all but a few progressing onto the important roles that hold the real power. I'm genuinely at a loss to explain how we have reached the current male dominated status quo. Surely, if true re-invigoration of audit is going to occur there needs to be a rebalancing of personnel. As someone who has worked with some of the best women in the business I welcome the day not when women rule the clinical audit world, but when they are at least equally represented in the key positions that decide the future direction and success of our profession.

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# Latest National News

### National Clinical Audit Advisory Group (NCAAG)

NCAAG are the strategic group formed in 2008 and chaired by Professor Nick Black.

There are two major updates to report in relation to NCAAG. First, their website has been overhauled and information can now be found via **www.dh.gov.uk/ab/NCAAG/index.htm**. The updated website is definitely an improvement on the original site and it is now much easier to locate relevant information, e.g. meeting minutes, list of members, etc.

Second, NCAAG have produced a two-page document entitled "What is clinical audit?" The document sets out NCAAG's views in relation to clinical audit and includes information on "what audit is not", "characteristics of clinical audit" and a new definition for clinical audit. The new definition is as follows:

*"Clinical audit is the quantitative assessment of the quality (principally the effectiveness) of care being provided compared either to agreed, documented evidence-based criteria or to the performance of other providers or commissioners. Its aim is to stimulate quality improvement and to assess their impact".*

NCAAG minutes from their latest meeting in March include a number of interesting updates in relation to national audits and the suggestion that the NCAPOP name will be changed to the "National Clinical Audit Programme". NCAAG next meet at the end of June.

### Healthcare Quality Improvement Partnership (HQIP)

The second quarter of 2009 appears to have been an exceptionally busy time for HQIP with lots of news to report. As a reminder, HQIP are a consortium made up of the Academy of Medical Royal Colleges, Royal College of Nursing and National Voices. HQIP hosts the contract to manage and develop the NCAPOP and will provide operational support in relation to clinical audit. Full details of HQIP's work can be found via **www.hqip.org.uk**.

HQIP's first national audit conference took place at the Belfry in April. The event included a number of keynote speakers, plus workshops to assess and evaluate the audit tools that HQIP have procured for wider use. The conference also incorporated the inaugural national clinical audit awards, with winners announced as: Hampshire Partnership Trust (Sustained Improvement), Alder Hey Children's Foundation Trust (Patient Involvement) and Southampton University Hospitals NHS Trust (Audit Programme of the Year).

In other news, HQIP have announced that they have consulted widely to develop a consensus on what constitutes clinical audit quality through a mix of qualitative and quantitative research. A draft list of quality markers for clinical audit are now available on their website and HQIP are seeking views from healthcare and audit professionals.

HQIP have also revealed that they are providing funding of up to £3500 per year to support regional clinical audit networks and bids can also be made for up to £10,000 per year to support multi-site audit projects. HQIP have also announced that Jane Moore has joined the HQIP team as Team Leader of the LQIT and they are still keen to recruit clinicians to champion the benefits of clinical audit.

The only disappointing news from HQIP has been the continued delay of the National Clinical Audit Forum. This promises to be an excellent multi-layered forum to help share views, insights and good practice. The forum has been promised since March but the HQIP website is now suggesting that launch may not take place until the end of June.

Finally, HQIP and the Clinical Audit Support Centre have linked together to discuss completion of the updated version of Principles for Best Practice in Clinical Audit. This is a logical step given HQIP's role in national audit delivery and we hope to provide more details of progress in the next journal.

### National Audit Governance Group (NAGG)

NAGG were established in November 2000 and are a group of interested people from several national and regional audit groups. The purpose of the group is to act as a "network of networks" for those in clinical audit and their website provides details of a number of regional audit groups, including: SWANS, SECEN, MEAN and GMCAN.

As reported in the last journal, NAGG have been reviewing their membership and we understand that the latest group to be represented on NAGG is Help the Hospices. It is slightly disappointing to report that minutes from the December 2008 meetings are still only available in draft format on the website and no minutes for meetings in 2009 are available.

The main news in relation to NAGG undoubtedly relates to NCAAG's new definition of clinical audit. NAGG have set up a special section on their forum where clinical audit professionals can make their comments known. This has led to plenty of valuable and lively debate with Robin Sasaru (NAGG Chair) stating that the new definition is "the biggest step backwards since Principles for Best Practice was published in 2002". If you wish to contribute to the debate or find out more about the work of NAGG please visit **www.nagg.nhs.uk**.

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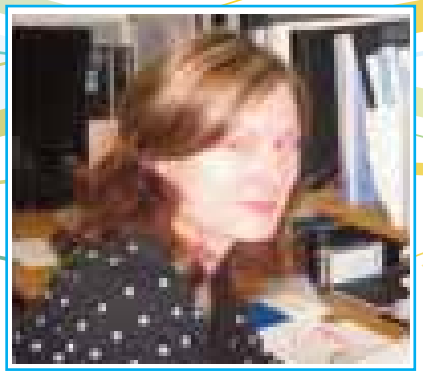

## HQIP at the Belfry: Hole-in-One or Lost Ball?

***By Gemma Barker, Clinical Audit Facilitator, NHS Nottingham City***

*I've been working my current clinical audit role for fourteen months, after previously undertaking prescribing audits for a PCT medicines management team and have also worked in secondary care undertaking audits of NICE guidance for cancer treatments. I have gained a place on the NHS Management Training Scheme and will start this later in 2009. This is my view on HQIP's first conference that took place at the Belfry in April.*

The inaugural Healthcare and Quality Improvement Partnership (HQIP) conference began with the ringing statement, from chief executive Robin Burgess, "this conference is not for HQIP, but for you!"

Robin then proceeded to whizz through the work of HQIP to date; they've promoted clinical audit with more than 10,000 communications, they've commissioned guides and tools, and are looking to produce guidance for junior doctors, patient involvement and for non-executive board members, and also have just announced a fund for multi-site audits. However, there was a big disappointment with the eagerly anticipated National Clinical Audit Forum not ready to launch, in Robin's words, HQIP are "bitterly disappointed", but unfortunately they gave no indication of when it would be ready!

Sir Bruce Keogh took to the stage and gave an invigorating speech about clinical audit in today's NHS, with emphasis on quality and pushing forward with reinvigoration and innovation. He also mentioned that NICE would be doubling in size over the next few years and would start producing 'quality standards' at the rate of 10 to 20 a year.

The session was rounded off with a rather odd Q&A panel about the future of clinical audit in the light of the electronic patient record. The esteemed panel of Robin Sasaru (NAGG chair) Martin Ferris (Head of Clinical Audit and Effectiveness, NHS Sheffield), Julie Royce (NICE Associate Director) Robin Ufton (East Kent Hospitals NHS Trust) and Helen Brady (Royal Surrey County Hospital NHS Trust) seemed to want to play it safe, and there was no clarity over what type of electronic patient record was being debated, as for many GPs electronic records are a reality, but in terms of a joined up patient record (that is, the 'spine') this still seems to be in the distant future for all.

One of the highlights of the first day was definitely the evening dinner and Clinical Audit Awards. Delegates were treated to a wonderfully decorated dining room, with a seemingly endless supply of free wine!

The next morning (with a few delegates inevitably nursing sore heads!) the day kicked off with Robin Burgess again recapping HQIP's work, followed swiftly by an interesting talk from Professor Nick Black (NCAAG Chair) on defining quality. He noted that there is a difference between audit and quality improvement, stating "improving quality is a different set of skills to auditing". He also gave an interesting description of where NCAAG sits within clinical audit, openly stating that they "just float around" in relation to HQIP, NCAPOP and so on! An interesting but rather concerning admission from the Chair of the main clinical audit advisory body to the NHS!

Julie Royce gave a rather long talk about the work of NICE, defining 'quality standards' as "statements acting as markers of high quality, cost effective care across a pathway/clinical area" and also discussing the work of NICE in terms of providing a list of their guidance for NHSLA assessors to use.

The remainder of the day two was given over to 'workshops' where delegates could debate and preview the content of the guidance and tools commissioned by HQIP.

We were informed that this was privileged information and we were not to divulge details to anyone outside of the conference – a curious comment given most attendees were expected to cascade information back to their respective Trusts! The general feeling from this delegate and others I spoke to was that the tools previewed would actually be of limited use. For example, a quick show of hands in the workshop on the tool for monitoring NICE compliance indicated that it would probably be used by around only 10% of the delegates in the room!

The conference closed with an interesting talk from Danny Keenan of the Care Quality Commission, discussing national audits. He acknowledged a number of factors that impact on national audits, e.g. poor quality data and timeliness of data returns. He also looked to the future and suggested national audit data will be used as a "screening and surveillance" tool that may link to service accreditation schemes.

Many of the delegates seemed to be very pleased to be at a national conference for clinical audit and the recognition of their work this confers, with some saying that they were still unaware of many of the national developments, and the work of HQIP. However, some delegates were unsure about the final utility of some of the tools HQIP had commissioned, and felt that this crowded and, at times, rushed conference did not significantly add any practical improvement to their working lives. Several delegates also commented about the incredibly poor clinical audit marketplace, for which the stands seemed very amateurish.

Overall, HQIP put on a good show for getting people excited and reinvigorated about clinical audit, but ultimately clinical audit professionals have to take responsibility themselves for improving clinical audit in their own organisation.

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## Forget Google, ask me!

### *By John Grant-Casey, Project Manager, NHS Blood and Transplant aka "Grumpy Old Auditor"*

*John Grant-Casey is a registered nurse and a bachelor of science, but still hasn't got a proper job. Instead he does clinical audit at national level, which he has been doing since 1992 when he left the wards in search of a more meaningful existence. He's still looking. He's audited in NHS Trusts, the Health Protection Agency, the Royal College of Pathologists and now blights NHS Blood and Transplant. He claims there is no other person in the country who has done as many national audits as he has, since he is now working on his 15th. Get a life!*

Ask any auditor today to throw away their computer, roll up their sleeves and do it the old-fashioned way and they'll offer you a cup of decaffeinated Red Bush tea in a mug bearing the slogan "We value everything you do, are, ever will be – in fact we can't live without you" and glance at their colleagues, exchanging pitying looks.

See, I've been doing this a long time, and back in the old days we had to audit WITHOUT a computer. **Without!** Yeah! Incredible, innit? See, in those days the whole point of a clinical audit department was to help the nurses and doctors to look at the quality of the work they did and try to help them improve. Excuse me a minute….

Sorry! Colleagues looking over my shoulder had just read what I typed and I couldn't think for the loud guffaws of laughter and comments like "In your dreams, Grandad", and "You wish!". Although one sweet little NHS Management Trainee with big, brown eyes opened those eyes even wider in amazement.

They're gone now. But it's true – that's what we were there for. You created standards in the same way, drew a questionnaire on a piece of paper (unless you could persuade a medical secretary to type it for you – anyone remember IBM Golfballs?), photocopied it (We weren't in the dark ages!) and then sent them round. When they came back you counted the ticks and added them up using the five bar gate system (yes, you do – it looked like this 𝍸). We worked out percentages using a calculator or via a percentage table (stop laughing!) and then wrote our report.

When I talk to staff in hospitals about audit they consistently tell me they would love to do it but they don't get any support from the clinical audit department. They have to do it themselves. They don't know how. One doctor told me he had braved the torrent of derision from his colleagues and forged ahead with an audit design only to be finally beaten when the medical records department told him that he, personally, like with his own money, would have to pay a fee per set of casenotes for the department to pull them from filing. Who the hell thinks that doctors are going to do clinical audits if they have to pay for the privilege of getting medical records, half of which are incomplete and illegible? And you thought I was crazy! You know what I would do? Put the toys down, stop worrying about what others are doing and develop effective local audits with me as the expert. One stop shop stuff. Try it.

**Audit non sufficit**

The family motto of James Bond, the famous 007 Secret Agent, is "Orbis non sufficit" or "The World is not Enough". Bond starts his day with a drink, sips his way through lunch, meets his buddies for cocktails, may polish off some champagne with the girl, and smokes like a chimney through it all ("Then he lit his seventieth cigarette of the day…") How he ever manages to play cards, drive, sail, swim, fight, shoot and all the other manly things he does, smashed out of his gourd and coughing as he must have been, is unfathomable. But he does. And although today he would be fined heavily and slapped in rehab quick as you please, his excesses seems to be taken as a given by his co-characters, who after all are all doing pretty much the same thing.

For the world of clinical audit, enough is too much already! HQIP, The Healthcare Quality Improvement Partnership, is aiming to produce a library of audits that can be shared so we can conquer the world of poor clinical practice with a veritable arsenal of audits that will put down any clinical counter-insurgence. Trouble is, we've tried that before. Remember NCCA? The National Collaborating Centre for Clinical Audit tried it and failed. I tried it when working for a Medical Royal College, and failed. No one has suceeded, and in fact no one will. Here's why. You design a bloody good audit in your Trust which asks the right questions and pulls out the areas of practice which don't comply with evidence based guidelines. You report back and point out the legal, care-related and economical risks of this non-compliance and suggest low cost, low tech solutions. And it works – things get better – Hooray!! Three cheers for Clinical Audit, Band sevens all round, please! But just cos you did it , doesn't mean anyone else can.

See, when you design an audit it is with the evidence base that **your** staff think they believe in. The audit is run because someone believes that in **your** hospital it would be a good thing to do. You design questions that **your** staff think are relevant and you collect data from a sample size that **your** staff agree means they can no longer go on ignoring bad practice. Now make that available nationally, and what happens? It's like buying a piece of self assembly furniture where the instructions are badly photocopied onto a piece of recycled toilet roll with instructions written by people whose first language is gobbledegook and who can't be bothered to consult a dictionary or an English speaking person. You get bits that don't fit, spare screws (why, when it says I should have 10 speckled-grommits size 10c, are there in fact 28?). To build the thing at all and make it work you have to cut bits off, assemble things differently and modify where the handles go. So it is with clinical audits. Because other hospital's doctors don't believe in the guidelines you used, don't embrace that consensus statement, and because they don't record some of the detail that you did, and don't have patients that fit into that category, and they do things you don't do, they end up reaching for the superglue and creating an audit which looked good in the box but which ends up being relegated to the back of a cupboard with that handy vegetable peeler someone picked up at the Ideal Home Exhibition and those oversized coffee filters which no one is going to cut down so they fit the machine.

Yes, let's collect examples of good audits. Yes, let's not reinvent the wheel. By all means learn from others, but let's **not** lose our local expertise. After all, if someone comes up with a really useful set of audits which any hospital could use, for which there are downloadable audit and analysis tools, what are **you** going to do all day?

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# It's NICE to share learning

***By Penny Barber, Assistant Project Manager – Systems, NICE***

This year NICE are again running Shared Learning Awards which encourage organisations to share tips for putting NICE guidance into practice. Short listed candidates will be given a platform to present their work to their peers at the NICE conference in December 2009. Winners in each of the categories will receive cash incentives to support implementation of NICE guidance within their organisation and there are also possible opportunities for further national and local press coverage for the organisation. In addition to the personal and professional satisfaction of being part of the awards, all shortlisted entrants will be offered free and discounted places at the NICE conference.

The submissions will be judged under three categories:

- projects covering general implementation systems or approaches including commissioning, financial planning and audit and evaluation processes;
- examples of guidance promoting health and wellbeing;
- projects focused on implementing specific clinical guidance.

This year we are looking particularly for examples around auditing implementation of NICE guidance. This can include systems and approaches to prioritising and undertaking audit as well as information on areas identified for improvement and the changes made to improve practice, patient care or services following audit. This is your chance to tell us what worked, what didn't work and what you learnt.

All submissions are also made available in the shared learning database which can be searched via the NICE website. The database, which now contains over 140 examples, is used by others to search for examples on how other organisations have put guidance into practice. Currently there are a number of shared learning examples demonstrating how audit has been used in the implementation of NICE guidance. Examples include audit and evaluation tools and examples of how audit fits into organisational implementation systems. Between January and December 2008 there were a total of 17,255 hits on the shared learning website from users looking at examples of implementing NICE guidance. NICE also use these examples throughout the year in various publications to promote good practice and share learning.


*Shared learning database screen shot - audit examples search from www.nice.org.uk/sharedlearning*

You can submit your examples of shared learning to the database throughout the year but the deadline for consideration for this year's awards is **30 September 2009**.

Are you interested in sharing your learning with your colleagues in the NHS and the public sector? Submit your entry to the Shared Learning Database.

**Contributing articles to Clinical Audit Today**

**Background:** the audience for the journal is intended to be clinical audit and governance staff and practising clinicians and managers with an interest in the subject. Clinical Audit Today is not intended to be a high brow, academic publication and we request that your article is written in plain English and focuses on everyday practice.

**Length:** 500-1000 words.

**Illustrations:** where appropriate please illustrate your work using charts, tables, photos, etc.

**References:** where appropriate, references should be included – Vancouver numerical format. Please also include links to relevant websites and resources.

**Submitting your article:** on the first page include the article title and names of all the authors. Please provide the details of which organisation is submitting the article and an email address of the principal author. Start the article with no more than five key bullet points summarising the article. Submission must be in Arial font 11 and text should be justified throughout. Any heading or sub-headings should appear in bold type.

Send your article by email to *info@clinicalauditsupport.com*. We will acknowledge your submission within 10 working days.

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## Does Clinical Audit do what it says on the tin?

***By Neil Hampson, Clinical Audit Advisor, Gloucestershire PCT***

*My career has seen me come full circle from working as a quality assurance auditor for Walls Ice Cream (Unilever) which is one of the largest ice cream production companies in the world, via a career as a District Nurse, to now working as a clinical audit advisor employed by Gloucestershire PCT.*

*DISCLAIMER: This article is my own personal account of how I see clinical audit and has no bearing on the organisation I work for.*

The analogy between my previous role as quality assurance auditor working for a multi-national company and my current role as a clinical audit advisor is probably closer than you may think.

The role of a quality assurance auditor involved following the journey from raw material to finished product. We had criteria and standards from measuring the quality of the raw materials, measuring and checking all of the production processes to testing the finished product, storage, and transportation to the consumer outlet. Notice how this is similar to the Darzi (2008) review and the ethos of following and measuring the quality of the patient journey from visiting the G.P., clinical intervention, rehabilitation, back to independence at home.

Everybody in the whole process was involved and contributed to the quality and audit process. I could pick any product and audit at any stage of the production process with specifically designed audit tools and templates. This is very similar to "Standards for Better Health" which states that all clinicians will be expected to be involved with clinical audit.

Even some of the terminology was very similar. The company's vision statement was "Working together for the best" and our aim was to become a "World Class Company". Uncanny isn't it? The ethos and philosophy is practically the same if you compare it to "World Class Commissioning".

However I would argue that the NHS has a long way to catch up before even coming close to the high standards, comprehensive quality systems and the 100% customer focussed attitudes when producing ice cream.

Question: Is the production of ice cream more important than patient care??

Don't get me wrong. The NHS quality agenda as a whole has moved on in leaps and bounds in recent years. However we still regularly hear of bad practice as in the recent Stafford hospital scandal where it has been reported that possibly up to 400 extra deaths were as a result of system failures. If robust quality systems were in place this would not be allowed to happen.

The recent initiative for the national re-invigoration of clinical audit and the formation of the Health Quality Improvement Partnership (HQIP) is laudable. And the vision of clinical audit becoming a profession in itself is a massive step forward. In fact I am one of the lucky few who have been sponsored by HQIP to study for the postgraduate certificate in "Clinical Audit & Effectiveness in Health and Social Care".

However something has been bothering me for the past eighteen months since I took on the role as a clinical audit advisor and finally the penny has dropped. I trained first as a nurse and then as a district nurse. The common strand throughout my training was the word holistic; in other words treating the whole patient, not just the medical intervention but the whole package – physical, psychological and spiritual. Clinical audit in its purist form is not holistic. It looks at a clinical intervention but doesn't allow you to take in the whole picture.

My concern is that the reinvigoration of clinical audit and its desire to be seen as a stand alone profession will result in clinical audit becoming remote and facing the danger of becoming a pseudo science or poor man's research. We can't let this happen. I want clinical audit to be totally inclusive and involve all areas of quality care, not just the clinical aspect. The signs are hopeful but the message needs to be clear.

The introduction of world Class Commissioning and the Darzi review (2008) make it clear that clinical audit should cover the whole of healthcare quality. Evidence of this is already becoming apparent with guidance emanating from HQIP implying that service evaluation and effectiveness are just as relevant and valid as clinical audit. When these are used in conjunction it is possible to form a whole picture of the patient journey from the beginning to the end of a medical intervention (as with the journey from raw material to finished product in the world of ice cream production). Therefore it is only logical that all three of these processes should be provided from the same source which could mean the re-organisation of some clinical audit departments. Just as the term "Medical Audit" was superseded by the phrase "Clinical Audit", perhaps the time is ripe to replace that with "Patient Healthcare Quality Audit" which describes more fully the holistic aims of achieving high quality healthcare. We need to be crystal clear about "What it says on the tin", to emphasise that we provide a robust patient healthcare quality audit system for all the health care professionals we support and to ensure that we put the patients, our customers, first.

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## Clinical Audit 2020 conference: The Third Way

*CASC's third national audit conference* will take place in Leicester on 16th September 2009. This will be an action packed event with the full programme now confirmed including: Dr Tim Brabants (Doctor and Olympic Gold medal winner), Professor Mike Pringle, Roisin Boland (CEO of the International Society for Quality in Healthcare), Boo Armstrong (NCAAG member) and Dr Paul Hodgkin (Director of Patient Opinion website).

The day will include short update sessions from NICE, NPSA, HQIP and NAGG. There will also be an Audit in Action hour featuring winners of last year's poster exhibition. Once again, the event will include an interactive exhibition and poster competition with a top prize of £200. Deadline for poster abstracts has been extended until the end of June. The conference takes place at the Athena centre in Leicester, an excellent venue with great transport links to major roads and Leicester Railway station. We are offering an early-bird rate until the end of June of £150 + VAT (£172.50) and for more details of how to book or receive information on the poster competition please email *info@clinicalauditsupport.com.*

*Tim Brabants pictured above: Tim won an Olympic Gold Medal at the Beijing Olympics and currently works as a doctor at Queens Medical Centre, Nottingham.*

*Basingstoke and North Hampshire Foundation Trust's audit team pictured above: BNHFT won the 2008 conference poster competition and will provide an insight into how they deliver successful clinical audit at a local level.*

*Professor Mike Pringle pictured above left: Mike is Professor of General Practice at the University of Nottingham. He is heavily involved in revalidation and patient safety work with the NPSA.*

*Lucy Warner pictured above right: Lucy works as a policy advisor to the Department of Health and is currently Chief Executive of the NHS Revalidation Support Team. She returns to chair the conference again this year.*

## Signposting

*Clinical Audit Today* would like to draw your attention to the following events that are taking place later in 2009.

### ISQua 26th International Conference 2009

The International Society for Quality in Healthcare are holding their 26th conference in Dublin from 11th-14th October. The theme of the conference is "Designing for Quality" and a truly "global" programme is being planned. Confirmed speakers include Professor Bruce Barraclough and John O'Brien and the gala reception takes place in Dublin Castle. The cost for attending the main programme is 1150 euros and more details can be found by visiting *www.isqua.org.uk*

### HQIP's National Summit

The 2009 national audit summit will be held on 3rd November 2009 in London. The theme for the day is embedding clinical audit into the quality agenda and Lord Darzi is confirmed as the keynote speaker.

The summit is aimed at leaders of national clinical audits, both HQIP and independently funded. For more information visit the events section of the HQIP website.

### Healthcare Events call for poster submissions

Healthcare Events will be holding their 11th annual clinical audit conference in London on 9-10th February 2010. As part of preparations for the event, Healthcare Events would like to receive abstracts for posters and oral presenatations. More details can be obtained by visiting *www.healthcare-events.co.uk*

**If you are holding an event in 2009/10 and would like this featured in a forthcoming issue of the Clinical Audit Today journal, please send details to *info@clinicalauditsupport.com***