The state of clinical audit

12th annual survey
Final report

'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 twelve years of comparable data. CASC set up the online questionnaire via SurveyMonkey and various invites to participate were sent out in November and December 2021. For example, CASC sent an e-postcard out to publicise the survey and once again we piggybacked onto Clinical Audit Awareness Week #CAAW21. The survey officially closed on 24 December 2021.

It should be noted that in 2021, we made a couple of amendments to our survey compared to 2020. This involved the return of a series of questions that were 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. These questions were asked in 2019, not included in 2020, but returned for this survey in 2021. In addition, we took the decision to remove the question that we have always used asking respondents to identify the 'least effective national clinical audit'. Over time we have considered that this is deemed a negative question and hence we removed it from the 2021 survey.

Response rate and respondents

Participation in the survey is optional. A total of 146 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 146 returns represents a small decrease compared to 187 in 2020 and 161 in 2019. It should be noted that this is the twelfth 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 146 respondents for section 1, the vast majority (61.6%) classified themselves as a 'clinical audit professional'. The majority of respondents stated that they worked in 'acute care' (59%). Years worked in clinical audit was varied. 43.8% stated they had worked in the profession for 5 years or less, 18.8% had worked in audit 6-10 years, 14.6% 11-15 years and 22.9% 16 years or more.

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=146:

Clinical audit professional	(90)	61.6%
Quality improvement professional with responsibility for clinical audit	(25)	17.1%
Clinical governance professional with responsibility for clinical audit	(21)	14.4%
Clinician with interest/responsibility for clinical audit	(6)	4.1%
Other*	(4)	2.7%

*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?

1 respondent skipped this question and 1 answered 'not applicable', leaving n=144 answer for Q2:

Less than 5 years	(63)	43.8%
6 to 10 years	(27)	18.8%
11 to 15 years	(21)	14.6%
16 years or more	(33)	22.9%

Q3 What sector do you work in?

2 respondents did not reply to this question, leaving n=144 who answered Q3:

Acute care	(85)	59.0%
Ambulance	(4)	2.8%
Community	(7)	4.9%
Mental health	(17)	11.8%
Partnership (community and mental health)	(15)	10.4%
Primary Care	(4)	2.8%
Other*	(12)	8.3%

*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

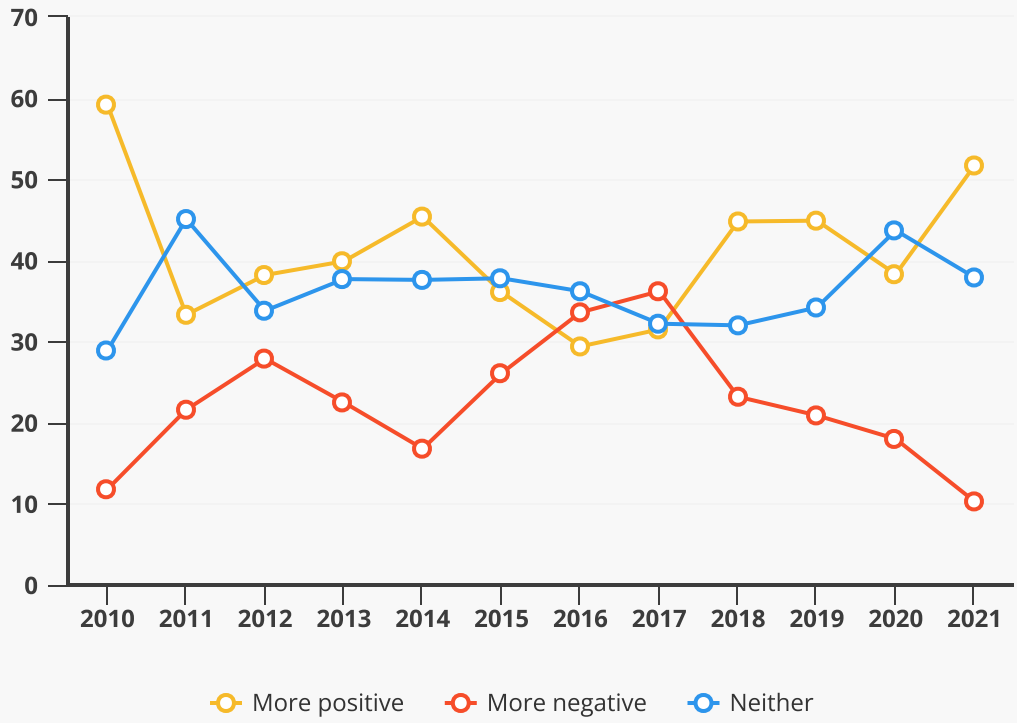
The following section, provides results for questions that were asked as part of the CASC survey.

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

1 respondent did not reply to this question, leaving n=145 who answered Q4:

More positive	(75)	51.7%
More negative	(15)	10.3%
Neither more positive/negative	(55)	37.9%

The graph below illustrates the significant changes in results over the last twelve 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 four surveys from 2018 to 2021 the number of 'more positive' answers has outweighed the proportion of 'more negative' responses and results for 2021 are very similar to those reported back in 2010.



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

2 respondents did not reply to this question, leaving n=144 who answered Q5:

Yes	(110)	76.4%
No	(34)	23.6%

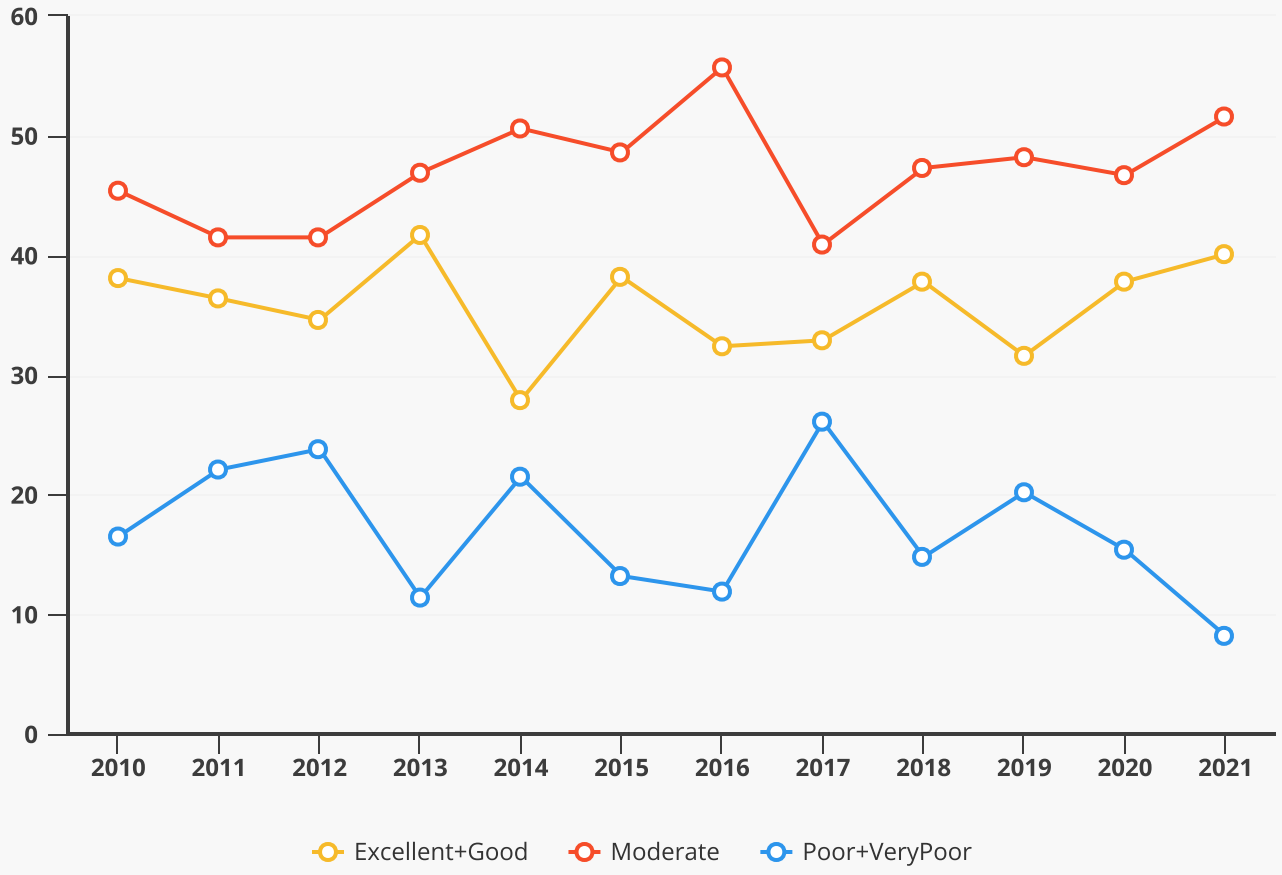
76.4% of respondents for Q5 stated they intended to work in audit in 5 years. This the result for 2020 was 64.5% and in 2019 less than 60% of respondents answered 'Yes' to this question.

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

24 respondents did not answer Q6 (1 skipped the question while a further 23 marked the 'not applicable, I have not taken part in national audits' option). Results for the remaining 122 respondents are as follows:

Excellent	(7)	5.7%
Good	(42)	34.4%
Moderate	(63)	51.6%
Poor	(8)	6.6%
Very poor	(2)	1.6%

The graph below shows for the twelfth consecutive survey the highest response to this question (even when 'excellent' + 'good' and 'poor' + 'very poor' responses were grouped together) was 'moderate' (51.6%). It is encouraging to see that the combined results for 'poor' and 'very poor' are at their lowest (8.2%) level since the survey commenced in 2010. 40.1% of respondents rated national audits positively in response to this question.



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: 54 respondents did not answer Q7, thus there were 92 responses to this question.

Sentinel Stroke National Audit Programme (SSNAP)	13
National Emergency Laparotomy Audit (NELA)	12
National Asthma and COPD Audit Programme (NACAP)	7
National Audit of Psychosis (NCAP)	5
National Hip Fracture Database (NHFD)	4
Prescribing Observatory for Mental Health (POMH)	4^

^It should be noted that POMH results incorporate a number of audits.

For the twelfth consecutive survey, SSNAP received the most nominations in response to this question. Indeed, SSNAP and NELA have been voted the top 2 most effective national audits for the last three years (2019 to 2021 inclusive).

Note: in previous years as part of the survey we asked 'what do you consider to be the **least** effective national clinical audit?' This question was removed from the 2021 survey.

Q8 Within your current organisation, would you like more or less national clinical audits to be made available?

44 respondents did not answer Q8. Of the remaining 102 respondents, the results were:

More national clinical audits	(32)	31.7%
Less national clinical audits	(70)	68.3%

In 2020, 60% of respondents to this question stated that they wanted 'less national clinical audits' The results show an 8% increase for this response in 2021. In addition to the quantitative data collected for Q8, respondents were also given the opportunity to add free-text comments (see below).

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: Q8b within your organisation would you like more or less national clinical audits to be made available? Q9 what is the single best attribute of national clinical audits? and Q10 what one change would you make to improve national clinical audits?

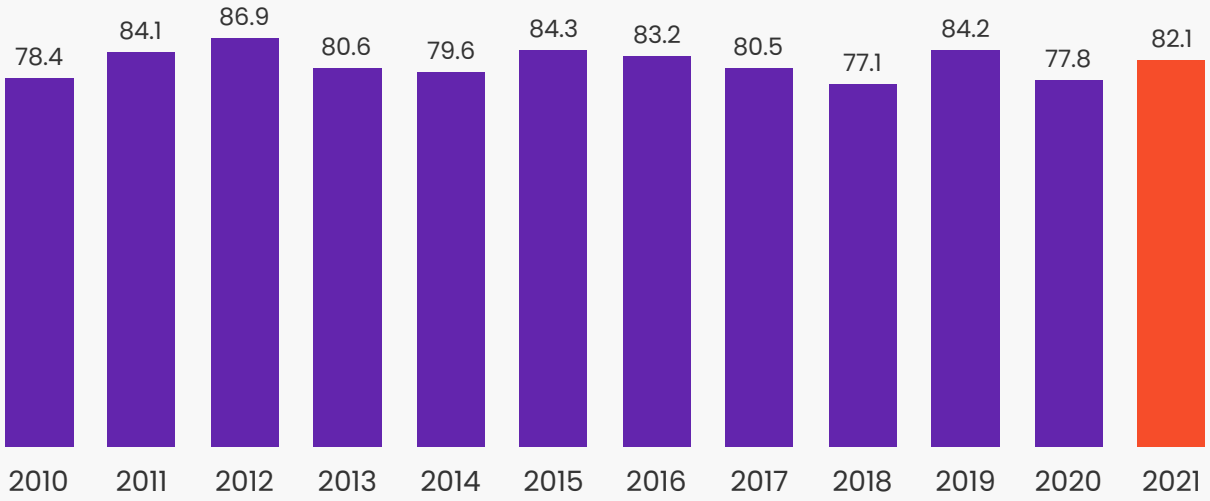
These three free-text questions have proved popular, with many survey respondents choosing to answer and provide feedback. All comments in relation to these three questions appear in the appendix section within this report.

Q11 In your opinion, which are the more effective at improving patient care?

23 respondents did not answer, leaving n=123 for Q11:

Local clinical audit	(101)	82.1%
National clinical audit	(22)	17.9%

For the twelfth consecutive survey, local clinical audit outscored national clinical audit by a significant margin. The result for 'local clinical audit' in 2021 is 4 percentage points higher than 2020.



Q12 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?

25 respondents skipped this question, leaving n=121:

0% to 20%	(26)	21.5%
21% to 40%	(36)	29.8%
41% to 60%	(32)	26.5%
61% to 80%	(21)	17.4%
81% to 100%	(6)	5.0%

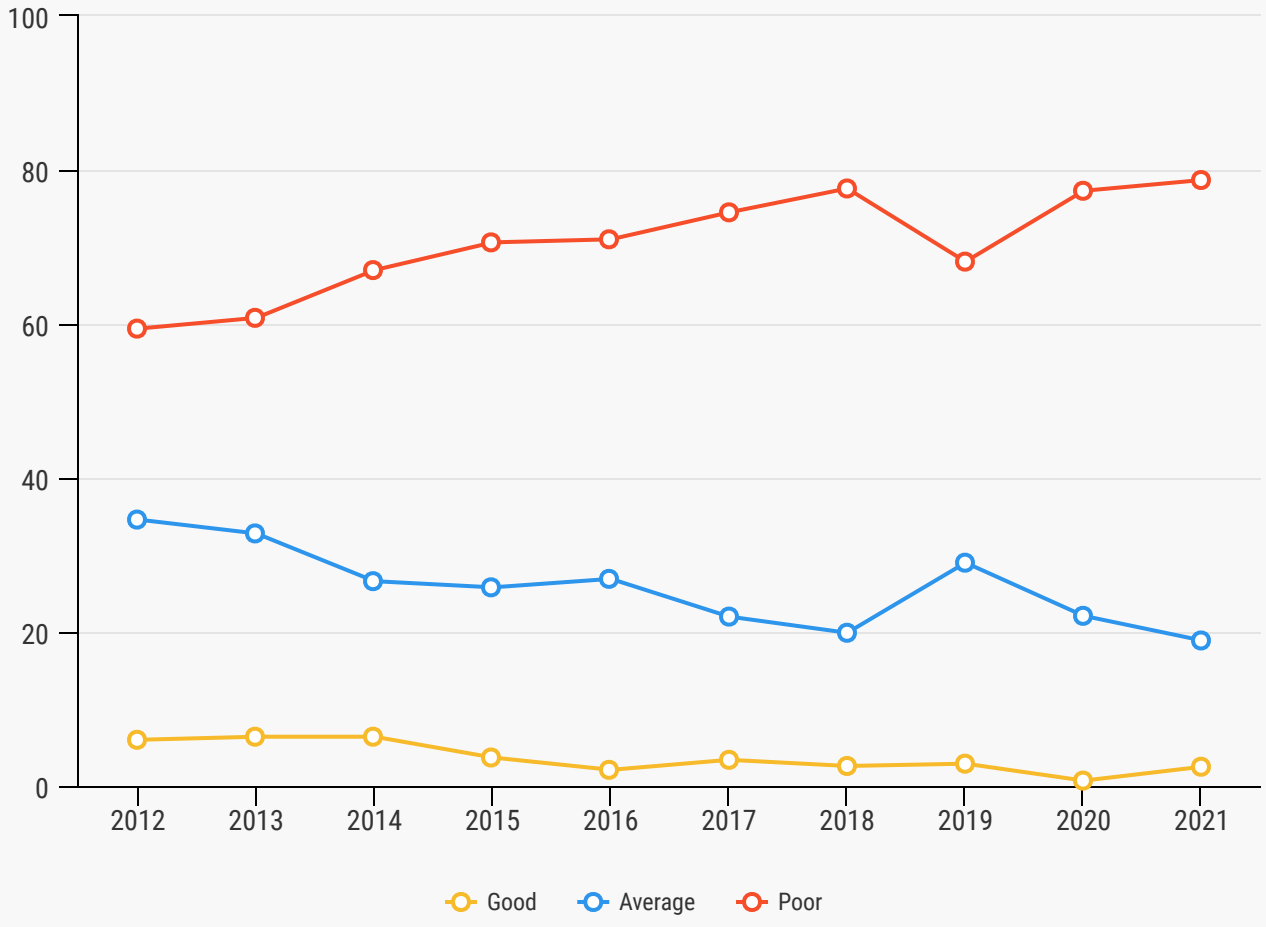
We appreciate that there is subjectivity with Q12, e.g. some teams carry out traditional full-scale re-audits, whereas others conducted targeted re-audits. The results for 2021 are similar to those reported in previous years and identify there is scope to improve re-audit rates.

Q13 Over the last 12 months, how would you rate the level of patient involvement in clinical audits you have taken part in/facilitated?

24 respondents skipped this question, leaving n=122:

Good, patients are heavily involved in clinical audit	(3)	2.5%
Average, patients are involved in some aspects of clinical audit	(23)	18.9%
Poor, patients are rarely involved in clinical audit	(96)	78.7%

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, the result for 2021 of 78.7% for 'poor, patients are rarely involved in clinical audit' is the highest result achieved since this question was introduced into the survey in 2012.

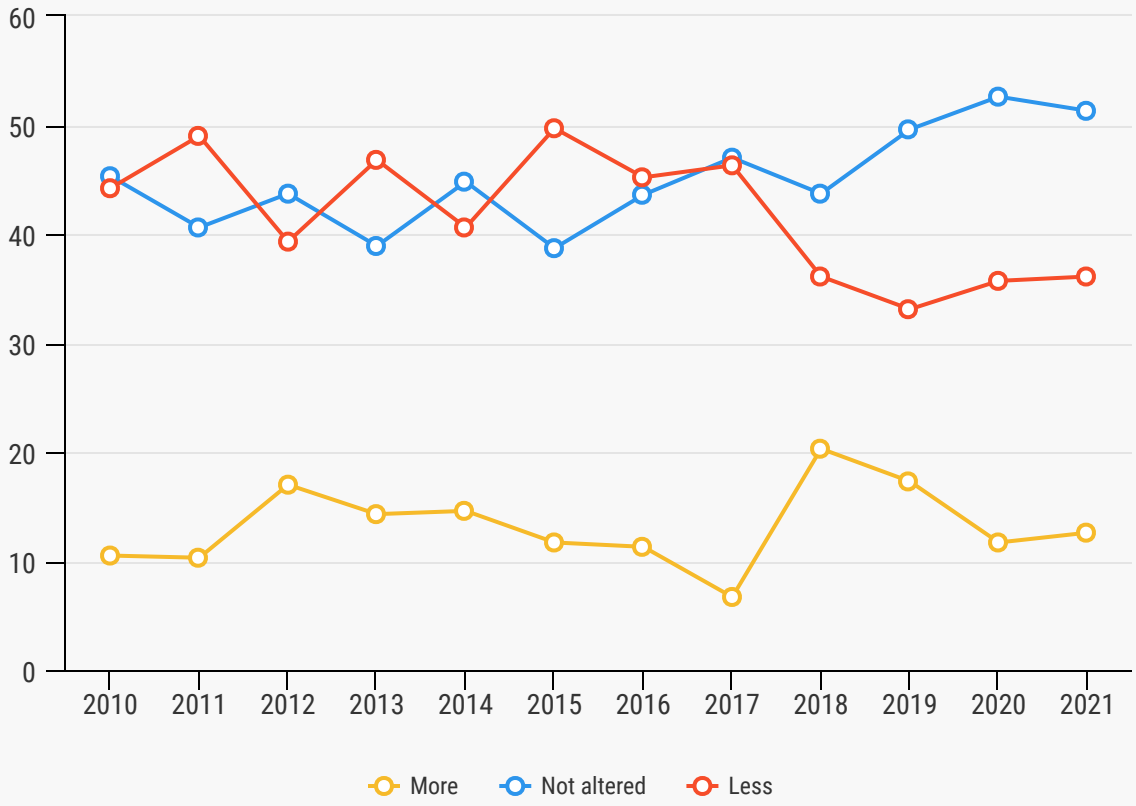


Q14 Over the last 12 months, what change has there been in the way clinical audit is resourced in your organisation?

27 respondents skipped this question, leaving n=119:

More resources available to support clinical audit	(15)	12.6%
Resources for clinical audit have not altered significantly	(61)	51.3%
Fewer resources available to support clinical audit	(43)	36.1%

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'.



Results for 2021 almost exactly mirror those for 2020. 1 in 8 respondents state that they have 'more resources available to support audit' compared to 12 months previously. However, over the last four years (2018 to 2021) those stating that they have 'fewer resources' has remained around 35% each year. Prior to this, those stating they has 'fewer resources to support audit' compared to 12 months previously was consistently between 40% and 50%.

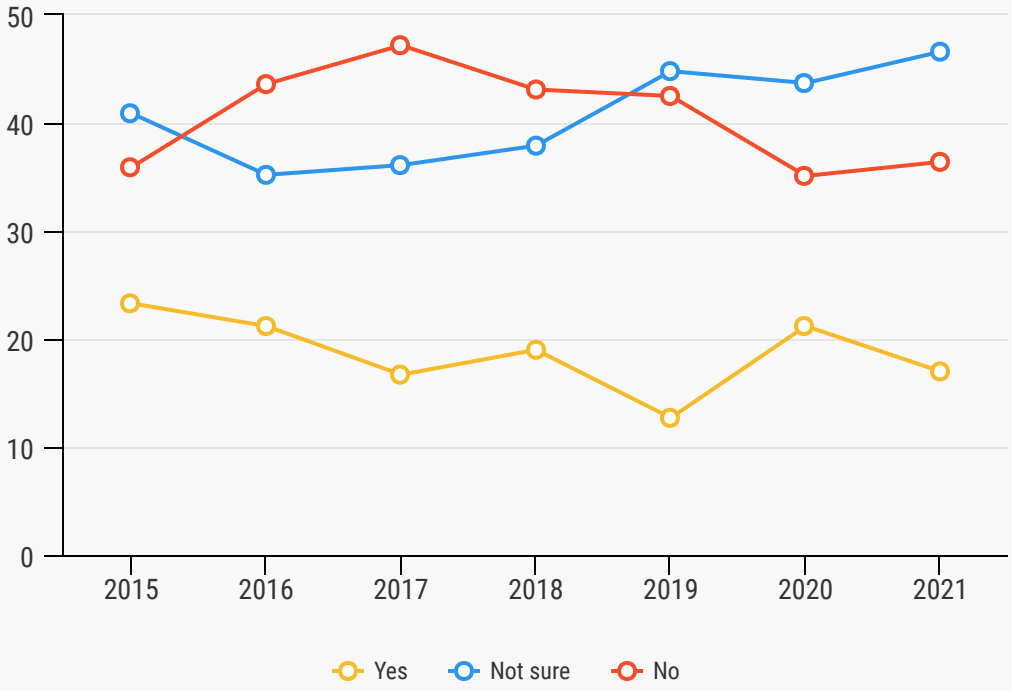
Q15 Ten years ago Sir Liam Donaldson stated that both national and local clinical audit needed to be reinvigorated. From a personal perspective do you think this objective has been achieved?

For national clinical audit:

28 respondents did not answer this part of Q15, leaving a total of n=118:

Yes, reinvigorated	(20)	17.0%
Not sure	(55)	46.6%
No, not reinvigorated	(43)	36.4%

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 seven surveys from 2015 to 2021:



Results for 2021 are very similar to those achieved in 2020.

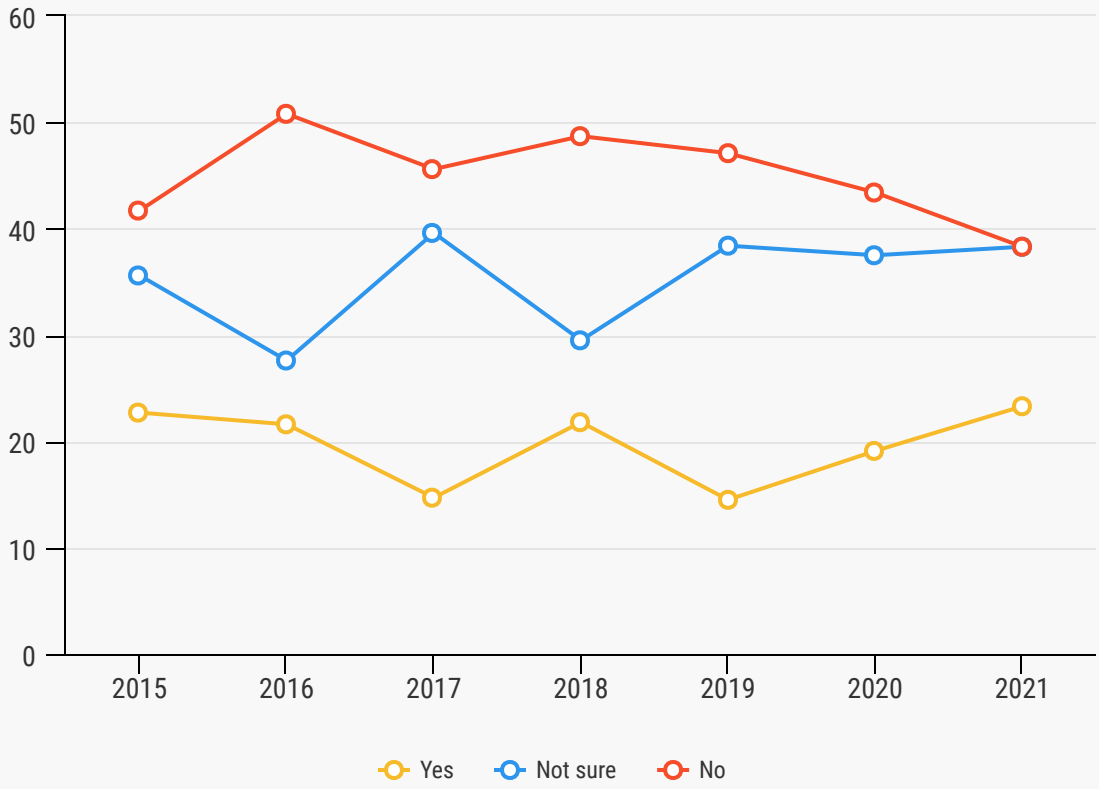
Q16 Ten years ago Sir Liam Donaldson stated that both national and local clinical audit needed to be reinvigorated. From a personal perspective do you think this objective has been achieved?

For local clinical audit:

26 respondents did not answer this part of Q16, leaving a total of n=120:

Yes, reinvigorated	(28)	23.3%
Not sure	(46)	38.3%
No, not reinvigorated	(46)	38.3%

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 seven surveys from 2015 to 2021:



Results show a considerable level of consistency and data for 2021 is very similar to the first results achieved in 2015. It should be noted that in 2021 we see two data points intersect for the first time.

Q17 Do you have any additional comments you would like to make in relation to the reinvigoration of clinical audit?

Free-text comments in relation to this question appear in the appendix.

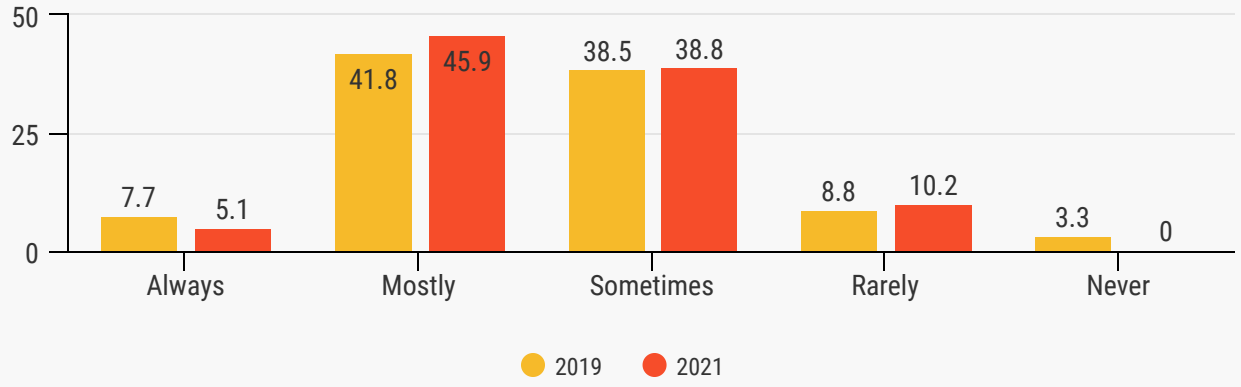
Q17 When accessing the websites of national clinical audits, how often were you able to find the information you need to know to plan for taking part, in relation to the following elements.

This question looks at five elements in relation to national clinical audit provider websites and relates to a project undertaken by Marina Otley and Roger Simpson. These questions were asked in 2019, not in 2020 but returned in 2021. This allows us to compare results from 2019 to 2021.

Q17a Which clinical services should take part

45 respondents skipped this question, 3 marked it 'not applicable'. Results for 98 respondents as follows:

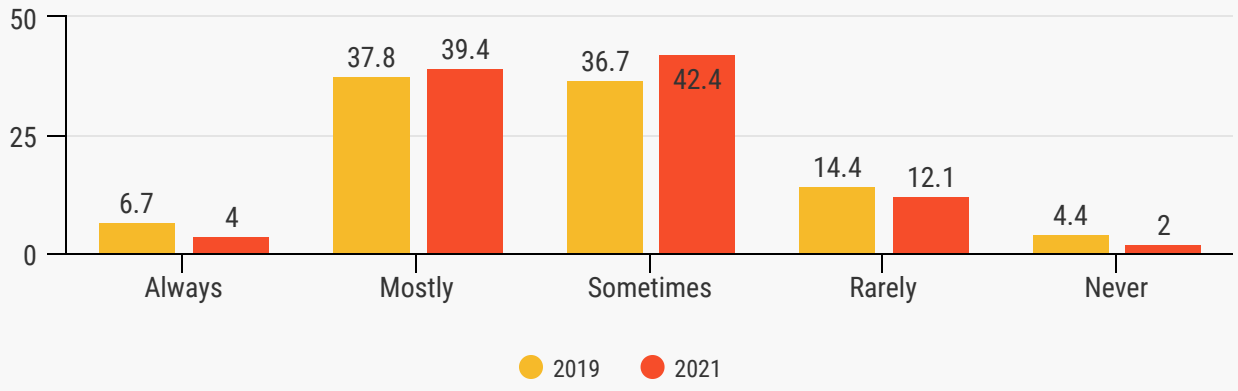
Always	(5)	5.1%
Mostly	(45)	45.9%
Sometimes	(38)	38.8%
Rarely	(10)	10.2%
Never	(0)	0%



Q17b Data collection details such as type, number of responses, staff time and how to submit

45 respondents skipped this question, 2 marked it 'not applicable'. Results for 99 respondents as follows:

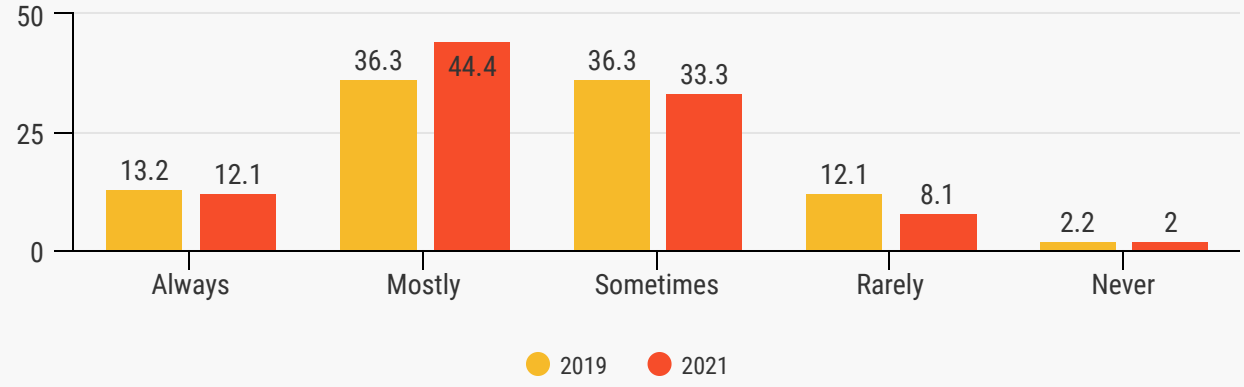
Always	(4)	4.0%
Mostly	(39)	39.4%
Sometimes	(42)	42.4%
Rarely	(12)	12.1%
Never	(2)	2.0%



Q17c Inclusion and exclusion criteria

45 respondents skipped this question, 2 marked it 'not applicable'. Results for 99 respondents as follows:

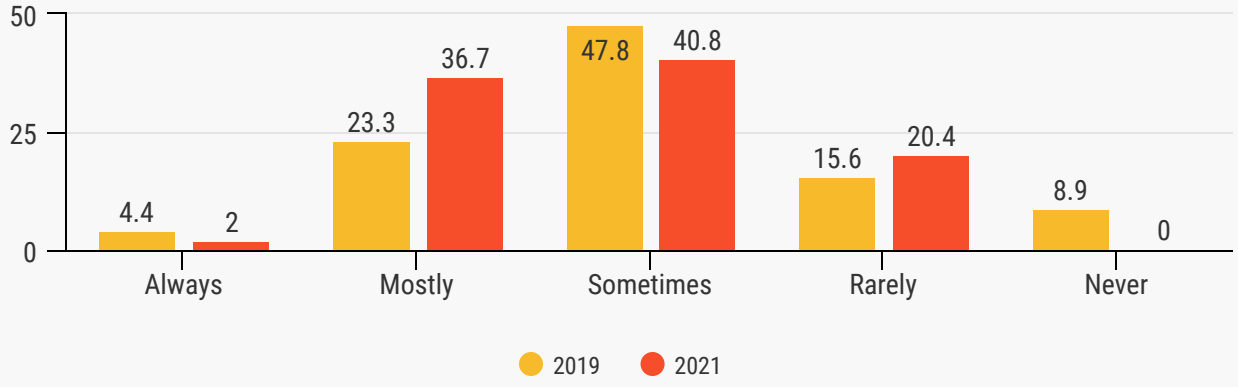
Always	(12)	12.1%
Mostly	(44)	44.4%
Sometimes	(33)	33.3%
Rarely	(8)	8.1%
Never	(2)	2.0%



Q17d Information governance basis (consent, s251)

45 respondents skipped this question, 3 marked it 'not applicable'. Results for 98 respondents as follows:

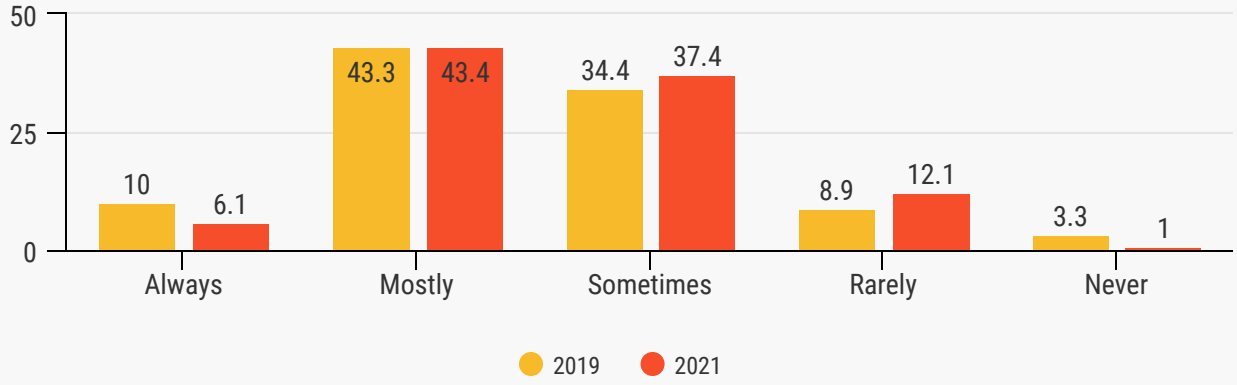
Always	(2)	2.0%
Mostly	(36)	36.7%
Sometimes	(40)	40.8%
Rarely	(20)	20.4%
Never	(0)	0%



Q17e Dates for registration, data collection, results and report

45 respondents skipped this question, 2 marked it 'not applicable'. Results for 99 respondents as follows:

Always	(6)	6.1%
Mostly	(43)	43.4%
Sometimes	(37)	37.4%
Rarely	(12)	12.1%
Never	(1)	1.0%



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 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 2021). We acknowledge that there are some limitations and the response rate could be higher, but for twelve consecutive surveys running over eleven 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 2022. 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 2021.

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.

Future plans

Given that this survey has now been run every year since 2010, we have decided to change plans in 2022. We will share results from this survey and make it available on the CASC website, but in 2022 we will be taking a break from the survey. In other words, the survey will not run in 2022.

The survey will return again towards the end of 2023. We will consult with the clinical audit community prior to the return of the survey to see if they would like the questions to be changed or altered, etc.

Appendix section

How would you classify yourself?

- Non professionally registered audit manager
- Healthcare professional with interest/responsibility for audit
- Clinical governance professional with a keen interest in audit. Previously been a clinical audit manager
- Senior manager.

What sector do you work in?

- ALB
- Combined: Acute, Community and Primary Care
- Public Health
- Hospice
- Acute and Community Trust
- Integrated Care Organisation
- Special Health Authority
- All and social care in the area
- Acute and Partnership
- NHS Provider.

NOTE: 12 respondents marked 'other' in the corresponding question, but only 10 gave a follow-up answer.

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

- A difficult question - perhaps IBD registry
- All national audits that I have been involved in over the years seem to generate the same sort of findings, but for me my most preferred that has changed slightly over the years is the NAD national audit of dementia, I love working on that audit and enjoy finding out about other trusts compliance
- Am not close enough to the results to comment
- Any that report in a timely manner
- Can't comment, have only been at the Trust 2 months
- Cancer diagnosis
- Clear standards measured against as sometimes they are just registers / survey rather than audits, less questions, trust level results and national level results, quicker reporting
- Diabetes
- Difficult question to answer, it can be topic specific, depending on where you work and your role. I think any national audit that's carried out well with the same targets / outliers to measure for comparable boards / trust can help identify areas for improvement. It can also set clinical recommendations that can be adopted nationally to ensure continuity of care. For example MBRRACE-UK works in this way
- Difficult to say as I am only involved in a couple
- Don't get involved in that many to say
- Don't know
- Early Intervention in Psychosis
- Falls and End of Life
- FFFAP
- For Mental health Trusts I would consider the POMH Audit on prescribing Valproate to be the most effective as it has highlighted and focussed attention on safe prescribing practices in Women of Child bearing potential
- From an impact on practice / a learning perspective, the National Confidential Enquiries
- Heart: National Adult Cardiac Surgery Audit (NCAP). Although since participating in this audit, I have changed jobs, I still lead on Clinical Audit within my new role, the facility specialises in Orthopaedics. My last few roles have been within the independent sector and we are limited within the number of National Audits in which we are able to participate in. We would love to be able to be more involved and welcome the new initiative to be included within more national audits
- I don't feel able to answer this meaningfully as don't have enough hands-on experience with enough national audits in my current role
- I feel this varies year on year, depending on which clinician is responsible. A more low key audit could be more effective than a more renowned one if the clinician really engages with the programme
- I have only taken part in collecting data for a POMH audit and the collecting and submitting of the data seemed very straightforward and easy to follow
- I think the national confidential enquiries have the most impact
- IBD registry - paediatrics
- If the data collected is current (not years old like NCEPOD) and a report is published swiftly, or at least the ability to review the data swiftly to maintain the momentum for action planning

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

- MBRRACE (x2)
- More trainings or course or learn at lunch to update any information regarding clinical audit
- NACAP
- NACAP (National COPD / Adult Asthma)
- NACAP and PASCOM (post op infections)
- NACAP COPD and Asthma
- NACEL
- NACEL due to focusing on end of life issues, especially in terms of person centred care at the end of life; POMH can be very effective at highlighting practice and safety issues within our Trust
- National Asthma and COPD Audit Programme (NACAP)
- National Audit of Dementia
- National Cardiac Arrest Audit
- National Emergency Laparotomy Audit (NELA)
- National Hip Fracture Database (x2)
- National mastectomy audit
- National Paediatric Diabetes Audit
- NCAP - when focused on Early Intervention Services
- NCAP EIP (x2)
- NCAP EIP audit is very well run and clear on information they want without the audit being too cumbersome or asking for a lot of different information
- NDFCA
- NELA (x9)
- NELA / SSNAP
- NELA and the NICOR
- NHFD (x2)
- NICOR Cardiology Audits (several)
- None available for primary care and so unable to comment
- None of them because the reports are out of date before you receive them
- Not sure (x2)
- Not sure, only involved in one
- Patient care
- PICANet and TARN
- POMH (x2)
- POMH audits and NCAP EIP audit
- Samba
- SSNAP (x7)
- SSNAP and NACAP
- SSNAP and TARN
- SSNAP or NACAP COPD
- Stroke (x2)

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

- TARN
- The BTS national audits are always well run, the protocol and instructions are published in a timely way to allow for planning within Trust and the reports are published in good time following collation of the data
- The most effective national audit is the one that has a good sound process in place and the clinicians/team engage is very well. For eg - SNNAP or NELA, process are robust, therefore pathway that they follow is easy to gasp
- The National Audit of Inpatient Falls
- The RCEM programme
- The RCEM QIPs are probably the most dynamic in terms of getting improvements into practice quickly
- They are all effective in their own way as they are looking at different areas
- They seem dis-jointed from local work and I don't see any liaison between the people running the projects and the Consultants that disagree with the results.

What is the single best attribute of national clinical audits?

- Ability to benchmark
- Ability to benchmark against national standards and other local organisations in order to compare performance
- Ability to benchmark against other organisations in order to drive improvements
- Ability to benchmark against other Trusts
- Able to benchmark against other similar organisations
- Access to local data to benchmark against
- Adequate resources
- Being able to bench mark and see any progress / trends
- Being able to benchmark against national data, and someone else doing the analysis etc
- Being able to compare practice with national results
- Being able to compare the service to other services
- Benchmarking (x14)
- Benchmarking - It is very useful to find out where your own trust sits nationally. Also, if you think you've got positive results, but actually they are significantly lower than national average, it is useful to see where you still need to improve
- Benchmarking against other Trusts
- Benchmarking and recommendations for improvement. Some provide real-time performance indicators. Improvement tools to support change where required
- Benchmarking it is always good to see how you are doing against other Trusts; good or bad
- Benchmarking performance
- Benchmarking with other Trusts
- Benchmarking / comparison
- Best practice
- Better practice
- Big data, faster changes to local services and a peer pressure to improve
- Clinical audits that allow you to benchmark against other Trusts, especially, where you can drill down into other hospitals in your region or units that are similar to your Trust
- Comparability
- Compare results on a national scale
- Comparison
- Comparison / benchmarking against other Trusts
- Consolidates and focuses on what we are or not doing well at a local level
- Enable local organisations to benchmark practice against national standards and with similar organisations
- Ensuring best practice is being followed on a national level - this may be auditing specific care delivery attributes that should be adhered to across services and sites
- Getting a national picture
- Gives focus on a topic of concern
- Good leadership and embracing change
- Good to benchmark

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

- Having the input of the project managers and team to assist with any queries no matter how small or large
- High profile, benchmarking, public reporting
- Highlighting patient safety issues against which we can plan improvements to patient care
- Improvement to patient care
- Mandated participation gives rise to the opportunity for greater learning
- Measuring performance for local services against national criteria. Recommendations from reports
- National Benchmark
- National benchmarking against best practice standards
- National benchmarking data
- National comparisons
- Nationwide picture can allow for better service planning if NHS England could ever be bothered to look at the results
- Opportunity to benchmark how a service is performing like for like with other organisations in both areas of good practice and where improvements can be made
- Opportunity to benchmark performance both for ourselves and against other similar organisations
- Peer-reviewed strong guidance and large dataset
- POMH can provide benchmarking
- Provide a comparison of care across a cross-section of healthcare providers
- Providing continuity of care for patients regardless of where you live
- Recommendations for quality improvement from a National audit - external standards and benchmarking cannot be ignored
- Reviewing care to identify gaps for change. (Improving care)
- Shared learning
- Shared resource and benchmarking
- Sharing knowledge and being able to benchmark
- Simple to complete by services and teams
- That they are trying to make some changes
- That they give Trusts the ability to benchmark performance against a national comparator
- The ability to bring about national improvement (if used properly)
- The ability to refocus organisations on the expected standards of care nationally
- The fact that you have a database ready to work on
- The identifying of areas of Improvement and assisting services in ensuring the very best actions can be completed to help with this improvement
- The more good data, the better
- They allow benchmarking against other organizations
- They give a view of other trusts performa
- They map improvements overtime and provide assurance on performance
- Timely benchmarked reporting
- To allow quality improvement to take place where it will be most helpful to improve patient care

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

- To be able to benchmark performance against other peer Trusts if they publish clear site specific analysis
- To compare all local departments to see the national average and where we are failing and where we can improve
- To see how the Trust compares to other's practice
- Trusts are able to compare performance nationally and make improvements to improve
- Well-written (i.e. not 'woolly') recommendations
- When they support data upload directly from the electronic patient record
- Where it is set up in a robust way, there are evidence based standards, with the analysis and report writing all done, therefore saving time. However this is not always the case
- You can compare with national average.

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

- A maximum number of data sets/metrics (e.g. no more than 10) that they are allowed to collect
- Acknowledge all the contributors
- All required to provide performance indicators / real-time performance against KPI's, improved reporting timescales
- Always to be relevant, not a tick box exercise with no learning
- An incentive for medics to action plan once outcomes received
- Be able to opt out if you clearly don't think it applies and don't see the benefit
- Better communication - from the outset it should be absolutely clear what is expected (even for rolling audits and right from the commissioning of new audits) with regular clear communication throughout the project, too many are vague at the outset and go quiet for months at a time
- Better data collection systems and communication from national audit teams. Most are good, but communication from some national audit teams is minimal and it is difficult to access support when an issue arises
- Better reporting aligned to which clinical areas they apply to
- BI data collection needs to be improved in our Trust. We have had to pull out of several audits as we have been unable to collate the specific data that matches sample criteria
- Clear standards. Stop registers
- Clear, concise, up-to-date information back to Trusts
- Clear, timely reporting (or is that two changes?!)
- Communication
- Consistency - they all seem to be so different in terms of data input system, analysis, report format and frequency, access to real-time data (some do, some don't), option for bulk uploading data direct from our trust systems would be a great benefit, as some web-based systems are too slow, clunky and require manual data entry
- Consultation with Trusts locally. This isn't easy, but would make them more invested. As it is we're debating whether to continue participating in the POMH-UK audits
- Deadlines tend to be every quarter, these need to be varied
- Early reporting well before the next audit cycle
- Easier access to trust data - although this has been improving considerably
- Easier data collection methods to allow audits to be less resource heavy
- Ensure that they reduce the burden of data collection and focus on measuring against best practice
- Follow up webinar shared learning type of event at a national level
- For someone to teach the NCAP audit organizers how to improve their data entry form so data entry for one form can be done with missing data that you can go back and complete later like in POMH forms
- For them to be less burdensome for clinicians, not so many patients to review. Some audits just go on and on - nothing changes as teams are too busy doing the audits to implement the changes
- ·For them to have less elements involved, for example NACEL, that has 4 elements to it that makes it difficult to get engagement

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

- For them to involve people who use services in design and the entire process
- Freedom to compare results with other organisations while national reports are being published
- Greater engagement with Trusts to implement the recommendations as there is no point each year asking the same questions over and over without the support to bring about improvements (or to establish if they are achievable)
- I have asked HQIP to bench mark the results for mental health audits, but some 3 years later, I am still waiting for this to be implemented
- I think the inconsistencies in approach to audits needs improving, the specific professions that are required to complete audit data collection needs to be clarified as there could be audits being completed by clinical governance facilitators that is better suited and more accurately represented if a medical colleague was provided the time to complete said audit
- I would make them less labour intensive by way of focussing on a smaller number of KPIs and ensuring that they are published within quicker timescales than currently to ensure that the data contained within the reports is still pertinent to local services
- Improve the quality
- Improve the spread across all healthcare sectors
- Improve timeliness of reporting - often by the time we get a national report the data is over a year old and things have moved on, so it's difficult to identify improvements
- Increase the timeframe for completing data collection and returns
- Increased engagement with local CA staff/regional networks during development
- Know your top 3 risks
- Larger samples
- Lengthy reports that nobody has time to read
- Less acute focus
- Less data variables and much faster reporting
- Live dashboards and tailored reports
- Make it easier for patients to access trust / hospital level reports
- Make the recommendations from some project less woolly
- Make the report more present time data
- Make them easier to deliver
- Make them more meaningful
- Make them smaller / more focused
- Methodology to include standards
- More consultation with and involvement from the types of organisations that have to do them
- More engagement opportunities for women's services so that local teams can see improvement rather than the mountain of paperwork
- More local reports, many of the National Audit reports only seem to publish National data
- More timely reporting of results
- More timely reports

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

- Much quicker turnaround for the reports - it would be great if there was more real-time data available
- Narrow the focus of each one; collect less data.
- National tool rather than each trust using its own programs
- Not all Trusts need to participate if you can demonstrate standards are met why keep repeating this
- Not waiting so long for annual reports to be published
- Off piste suggestion: make all NCA providers demonstrate how the work they undertake is value for money. I anticipate their argument will be that the value of their work lies in improving patient care, but how many of these pieces of work are held to account in relation to proving they truly represent value for money? I have never seen a mini-study comparing impact of NCAs and then linking it back to how much money the providers are paid. I suggest that would be an invaluable, ground-breaking and eye-opening study
- Perhaps the publishing process could be worked on, sometimes we wait 2 years to ever see an audit report by which time data is considered old and may not be as relevant as before
- Perhaps the timing of them, in our board a lot come out at the same time, if they could be more spaced out through out the year, anyone providing support or clinical leads who have to investigate it, may be the lead for more than one report so spacing it out would reduce clinical pressure with the time staff would need to investigate any outliers
- Quicker results
- Quicker turnaround of reports so relevant for the now not in several months time
- Quicker turnout of data and reports to enable quicker action upon problems found
- Real time reporting
- Reduce recommendations
- Releasing local clinical audit support staff if clinical audit facilitator to facilitate audits rather than the administration of national audits. It is evident that Clinical audit Facilitator roles are being replaced with Clinical audit Officer and Clinical Audit Administrator role, which are office based all the time, chasing national audit data, or in places like Sunderland Royal redrafting national audit reports into meeting templates. As was warned by the profession in 2012, the profession is being deskilled at an accelerated pace. More jobs are appearing but these are also on a downward pay scale. I feel more positive about my clinical audit future, due to my job change. but not positive about the profession's future
- Reporting time scale
- Require them to report back more quickly
- Rigour and design
- Sadly one change wouldn't be enough to make an improvement. If they listened to us it would be a good start. Apart from that getting the report out in a timely manner so that actions can be put in place and implemented into every day practice (standard audit procedure) before the next round starts. E.g. NCAP EIP report received in September, next rounds starts in October
- Simple data
- Some external providers lack experience in clinical audit and this is reflected when audit teams are trying to work with them. I would want there to be more involvement with audit teams before audits are launched. For example, following research based approaches, changing audit after it has been released causing higher workloads on teams, data collection forms not including all options on electronic forms etc)

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

- Some have very long data collection forms - this immediately puts clinicians off wanting to take part and makes it almost become a tick-box exercise for them
- Staff engagement
- Standardise reports and ensure they measure against criteria. these are then reflected in all reports. Timeliness of reporting. Access to have local benchmarking against other like for like trusts. Access to one platform where all findings are in one place
- The amount of time it takes to receive the results back
- The length of time that it take for the report to come back two years is too long
- The questionnaire needs to match what can be printed. we have staff who print the questionnaires to go through with some service users, but the printed versions do not indicate when one question should only be answered if for example you had to say yes to the previous question
- The results have to be made available within months if not days of completing the audit. RCEM does this. i can see the results from everything put in up to the day before I pull it. I can not get anyone to care about results from 2 years ago. it is a waste of our time and the clinicians time
- They should publish infographics at a site-specific level. They are quite happy producing good infographics for their national results but these can be difficult to map to a local level. National Clinical Audit Benchmarking produced by HQIP are good but both use limited number of criteria and not kept up to date at the same timeframes of the publications
- Timeliness of reporting
- Timeliness of results - ability to access results within weeks, not months (or years in some cases!) so that improvement can happen as soon as possible
- Timely reporting
- Timely reports (x2)
- Timely reports that answer the original criteria set
- Timely / quicker reporting, even if only data/ results being released before a full report is published. The sooner issues can be identified the sooner they can be looked locally
- Timescale for getting results - real time results
- To ensure you are benchmarking against Trusts that are similar to your own, otherwise benchmarking is meaningless as comparing apples with pears
- To have real time/up to date data
- Wider inclusion criteria.

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

- As an acute trust most NCA's are applicable to us. It would be great if we had the resource to facilitate
- At this time the continuous data collection and the shear number of projects is overwhelming and it does not give some of the smaller clinical groups support audit within their groups
- Because most of the national ones link to doctors cases and doctors do not seem to be committed to the process, or to take the results and reports seriously or do anything about the results
- Because the reporting back of the data is slow
- Benchmarking and best practice and aids to influence commissioning of services (with evidence) if there is a gap in care provision
- But more timely reports - National Inpatient Falls report for 2020 was published 1/12/21 but it will be another couple of months before a Trust one will be published before you can start to compare practice
- But only if they are well designed in collaboration with community trusts and provide reports in a timely way
- Catching up from the backlog from COVID when we paused has and is still very time consuming
- Current numbers are already difficult to resource. Would be better reducing numbers but improving quality and relevance
- Difficult to answer I wouldn't say we need more or less, any national clinical audit if its done well can be hugely beneficial to an organisation as it allows you to compare how you are preforming against boards/trusts similar to you. Having national recommendations can greatly improve continuity of care and allow boards to share ideas and learn from each other. We have quite a few national audits within our organisation, but equally local audits can be just as important to help identify some smaller specific issues within a particular service or measure how well any new recommendations/changes are working to improve patient care
- Doesn't focus on local issues
- High quality clinical audit projects are welcome. Primary care does not need or want the unnecessary vast data gathering exercises that acute trust are mandated to complete. These really only serve the research interests of the Royal College clinicians and don't practically illicit change on the frontline
- Huge amount of work for little return. Data out of date when reports published
- I don't think that clinicians necessarily read/respond to the findings, but spend a lot of time inputting data. I think this time could be better spent addressing local priorities
- I feel engagement would be higher if the already stretched clinicians had fewer audits to look after, especially within the Medicine division
- I feel the time lag involved in reporting does not help clinicians with improving the quality of their care.This results in national audits feeling like a tick box exercise to them, as it does not feel clinically useful
- I feel there are now too many - teams spend too much time on national audit rather than local audit. Being more of a balance would be much more helpful to enable teams to measure local audits against national audit
- I joined my Trust in March this year. Although we were undertaking national audits, awareness and engagement had fallen behind and being new to the Trust, I added all nationals that said they were either mental health or community to our programme. Next year we will be able to streamline this following the feedback we've had over this year

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

- I think more national clinical audits would be great to get a wider perspective on care nationwide, albeit resources available to complete more audits are limited and I know local, trust specific audits are felt to have a wider impact as it is more specific to a service
- I work in a partnership trust and would like to see more national audits relevant to my sector BUT only if they are high quality audits that follow a clinical audit methodology. I don't want to be involved in the vast data trawls that my acute colleagues are forced to participate in
- I would like to see less audits, with larger samples, whilst POMH can be a really effective audit, when it is split into sub-samples we may only have 10 or fewer patients in that sub-sample and it doesn't make the audit feedback as meaningful. Additionally we have a large number of teams within our trust and some teams may only have a very small number of patients within our overall sample and again the results often lack meaning for those teams. We also have difficulty involving clinicians in National Audits and having less National Audits with larger samples may help us to increase engagement
- I would probably go with less, I am the facilitator for the medicine division and majority of our audits are national
- I've just moved from an acute trust to a community trust. I would like more national audits towards care in the community but am anxious there would not be the support for them
- If the resources were available for both clinical and admin side then the volume of audits is currently fine, however, the reality is that these are very often just dismissed as a data collection and not often enough used to their full potential with the outcome of improvement
- If we got results more quickly I would see the benefit in doing more
- Important to have the time to implement learning properly
- In Mental Health, we only have access to 2 audits per year, this is not good value for money when HQIP want £10k
- In our hospital we have more than 53 national audits we participate in. Many national have duplicates and if there is a better ICS to take our HES data and turn them around, this would save all the hospitals time they use for national data gathering to use effective for snapshot to local improvements quarterly
- In the current climate, I feel the clinicians have massive workload, Audits are there for a good reason, but along with CQC action plans, GiRFT etc there seems to be a lot of duplication and not enough work hours or resources to complete
- It is a good bench marking tool. in order to improve we kind of need to see how other trusts compare, and in order to make sure we are all doing the best as per NICE standards etc.off the top of my head we only have the standard same sort of audits year in year out. although it is quite a lot of work for a small audit team like ours it can be enjoyable, i love the order that the audit takes and the preparation aspect, i think we should probably incorporate the planning into our every day business as its just fabulous
- It is a struggle to participate in the ones currently. To add more would certainly overwhelm our clinical staff. Keeping the same would be fine. Or a few less

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

- It would be good to have other national audits available for our community trust however it is essential that these are relevant, applicable, and valuable to those who take part i.e. demonstrate where effective practice takes place, areas for development, and benchmarking to other similar services
- Less but of more relevance. The resource required to collect data for National audits is a huge ask for busy teams
- Local audit has been squeezed due to the constraints of pandemic. National audits offer clinicians/ teams/ professionals national performance comparisons & can therefore focus minds on areas to review locally. The national audits have to be well thought out & meaningful however, there are a few too many appearing that are not on the HQIP QA
- Local of mental health focused clinical audits
- Lots of trust priorities on top of the national priorities, and the clinicians barely have time to keep up with clinical work currently
- More - but with the required admin support and clinician time to be able to review and act on the results
- More Clinical Audits & benchmarking data if timely reporting available - once we move to an EPR though
- More focus on local issues and QI
- More focused as there are a lot of national audits especially within my organisation
- More national audits would be better to bring mental health / community services in line with acute but they would need to be shorter and easier to manage
- My last few roles have been within the independent sector, due to not meeting the set criteria we have not been able to participate within many of the national audits launched. We are eagerly anticipating the new initiative in which the independent sector can be more involved. My last role allowed me to participate within the Heart National Adult Cardiac Surgery Audit which was really interesting. My current role has allowed involvement within the pilot for Cataract surgery
- N/A, recently changed roles, to an NHS provider, that provides some community and urgent care service, but not taking part in any National audits. But local audits are done across all Urgent care centre's we run, so king of an internal national audit for us.
- National audits are a great way to compare practice and standards against other hospitals or care settings by comparing local data and therefore can be used as a marker to improve the quality of care and practice. I'm not sure more National Audits is the best way forward as national reports can take a long time to be published. During the waiting time for national reports to be published, local audits are ongoing and these stem good timely results. There needs to be a better system or a process for comparing results with other organisations while waiting for national reports to be published. Perhaps there should be local agreements in place within regions to allow sharing of findings so we can bench mark against other organisations while we wait for national reports to be published
- National audits take a lot of time for clinical teams which is in addition to their workloads especially during the pandemic. Whilst it is good to be able to measure how services have been affected by the pandemic the audits have increased work load

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

- National benchmarking is a good way to measure and celebrate the care that is being provided and facilitate standardisation in care. The national priorities and evidence based recommendation can be measured and gaps can be identified
- NCAs continue to be resource heavy
- Only more national clinical audits if the reports are more timely and with more accessible local data. It is very difficult to engage clinicians in the review of data when it is more than a year old or when there is no local hospital level data to enable benchmarking against the national results. Data collection should also be easier with less duplication of data items between some of the national audits
- Or more joined up data collection. Not by Royal college as a patient who falls, may also have COPD and heart failure, yet all collect separate information
- Our trust covers a lot of services and it is difficult manage the number of national audits which apply to us. The information from the national audits can be useful however the audits do not tend to be very catered for the activities which take place in our trust and it is difficult to get Clinical leads to engage in the audits because the questions being asked by the Nationals are seen as relevant. fewer more bespoke audits would help to rectify this issue
- Quite a high number required for a busy Acute Trust - many are moving to continuous data collection which has increased the time and resources required. Some specialties are top heavy in national audits such as Cardiology, Diabetes and Respiratory
- Reduce burden on clinical staff
- Same
- So much time spent entering data but changes to clinical practice/improvement in practice not always identified / made
- Some of the audits are excellent but many take up vast swathes of staff time and for little reward. Reporting timeframes are long and by the time we receive results back from most national audits the services have already changed based on local audit and evaluation work. One of my colleagues was forced to cancel clinical commitments to complete the data collection for a national audit I find this set of circumstances unacceptable
- Staff seem to have more ownership of the audit started in house
- Staff struggles with current number and would be better to do them in cycles rather that repeat each year
- The balance is just right at the moment
- The imbalance in the current programme gives the impression that what happens in acute trusts is more important than what happens in other providers, however community trusts, GPs and mental health trusts are far more likely to see more of an individuals healthcare journey than the acute event focus of many of the national audits
- The methodology can be questionable at times

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

- The reports we receive from National audits are significantly out of date / based on old data that may no longer be relevant to how the Trust is currently operating. They are full of recommendations, many unachievable and they are not SMART. We have to do benchmark improvement plans against the National reports which is a huge piece of work initially and then ongoing to monitor all of the actions that come out of them when we have benchmarked against them
- There are a huge amount of MMBRACE audits in Women's services and it is hard to see the affect these are having in the local departments, our department is currently struggling to complete 2016 data and find any engagement for staff to be involved and there are more and more assessment of compliances they are being asked to complete
- There are a significant number of national clinical audits for which participation is mandated. This puts a huge burden on the already stretched workload of clinicians and nursing staff. A smaller number of well thought out national audits which focus on smaller numbers of KPIs with reports published within 6-12 months following data collection would be welcome
- There are limited national audits that are appropriate for community trusts, so it would be good to have some tailored to our services
- There are not many for Mental Health compared to acute care
- There are several NCA's in which the organisation does not take part due to the Trust simply not providing the services being audited. However, this leads to gaps in the market especially in relation to some major surgery audits, mental health and paediatric audits
- There are too many mandatory national audits which do not have any impact on patient care. Better to concentrate on fewer projects that are going to focus on improvements
- There isn't enough time for the clinicians to participate in the audits we currently have, plus not enough action is taken post audit as they do not have time to properly review the results and plan for change
- They are quite resource intensive and as staff are already stretched passed capacity, participation in these National Audits may prevent them from working on local projects that could have more immediate improvements
- They are very time consuming for clinicians and less of a priority to current demands on clinical practice and therefore usually get left as a result
- They give too broad a picture. Most seem written for acute trusts so as a community trust the data we get back is often not that useful. A lot of the areas we 'fail' in we aren't commissioned to provide
- They're a lot of work and require buy-in from too many people within the organisation - this could be mitigated by the trust being better organised for participating in national audits
- This has come up with National audits in clinical audit discussions at various committees. I would like there to be more focused local clinical audit projects if this was to happen, however I feel excuses would be made to do other things
- This will allow for teams to focus better on the ones they do participate in, for better and more detailed outcomes and local work to be carried out

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

- Those of us in the acute sector continue to be overwhelmed by pretty average national audits. These often continue to take a long time to process data making their results of limited value. Has anyone in a national audit team tried to convince local clinicians they need to change the way they work based on results often more than a year old
- Time consuming and take time away from local audit programmes within the organisation
- Too many for acute - these are also becoming continous data collection. This is putting pressure on resource for those who do not have electronic systems. There should be a gap to allow clinical teams to put in place improvements. Sometimes Less is more. if we were to take the approach of mile deep inch wide and concentrate on a smaller programme we will see more improvements. We are spreading resource to thinly which then lacks the intervention with the improvement side of things
- Too time consuming and far too long to wait for the results - especially if there is an issue that needs addressing
- We are a small acute Trust with limited resources. Clinical Audit is all about improving the quality of what we do. With so many mandatory National Audits we don't have the space to focus on areas to improve because there are too many, we need less so that we can focus on key areas to make improvements. There should be a maximum number for each service to make it fairer. The quality of the audits is sometimes questionable (collecting lots of data which doesn't all get reported on), the data can be years out of date (our Consultants' biggest gripe which we can't disagree with) and some of them lead to more work to be able to make the necessary improvements (e.g. NCEPOD). The danger we have at the moment (exacerbated by the pandemic) is that clinician time is so precious and needed to focus on treating patients/saving lives. This year we have a small respiratory team who have National COPD, National Asthma, BTS smoking cessation, BTS Pulmonary Embolism and Lung Cancer. We've also got significant pressure on our ED services and we are having to participate in the Royal College of Emergency Medicine audits. It is increasingly difficult to get our colleagues engaged when they are under so much pressure
- We do not have time to do local priority audits due to the number of national requirements we have 59 this year. there is no way we can ensure that good learning comes from them. We partake on average in 40 National Audits each year there is a lot to manage; especially when dealing with reporting we really struggle to get any traction on these, or leads, or recommendations written or embedded following the audits. We try to align resources to local clinical audits, but find our support has to go the national audits, because they are so comprehensive and time consuming. Less would be better quality, and more timely reports
- Well same number but with adequate resources focussed on data collection and ensuring sustained improvements in care provision
- With the exception of POMH and NCAP (EIP) and NAD some of the others we have participated in are not that relevant e.g. NACEL care at the end of life, whilst applicable for our community side we found it not relevant at all for mental health side and this is reflective of our responses with were all mainly 'no' - that felt like a lot of effort for very little return, would rather spend time and resource on internal projects
- Within my current organisation there is a number of national clinical audits but with work pressures there is not always someone available to complete the audits. COVID, business continuity have had an impact on all areas.

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

- Can feel like a hamster wheel going from one National audit report to another, working with historical data so Clinicians loose interest. Local audits can be hard to complete sue to pressures on staff
- Clinical audit is in danger of being overshadowed by QI. Clinical audit is QI. The best projects we find start and end with an audit with a QI project in the middle so you measure compliance at the start, do your QI and measure compliance at the end to see if the change has worked. To reinvigorate National Clinical Audit the quality of these need to get better and the number need to be reduced - this will then lead to local audits being commenced in response to national audit findings
- Clinical audit is still largely seen as an assurance activity with the report and action plan as the end product. The focus needs to shift to improving quality of care
- Clinical Audit overshadowed by QI Team development and is only recently being identified as one of the best indicators and drivers of improvement
- Clinicians are far too busy to get involved in audit or QI in a serious way and give it the time and thought required
- Dedicated QI teams have overtaken Clinical Audit in priority within trusts
- Difficult to comment on because not worked in this sector for long enough
- Fair pay for Audit professionals to be alighned with Quality improvement professionals. Comparing job roles QI jobs are usually higher banding / pay
- For the reputation of National clinical audit to change, projects need to be more specific - shorter, easily collectible data with clear, clean reporting and good support available for queries and issues with data portals etc. The providers need to be clear when organisational data should be collected (often very time consuming process with short turn-around)
- HQIP do not seem to be providing the umbrella of consistency over all the NCAs. I would have at least thought that they would inform trusts when NCAs are due to start/end, but we seem to have to visit specific provider websites to find all this out ourselves. Not at all a nationally co-ordinated approach
- HQIP don't have any sort of profile anymore most of my clinical colleagues don't know who they are. I have attended a couple of Learn at Lunch sessions by Clinical audit Support Centre, excellent resource and recommended to colleagues
- I don't think I can see clinical audit without seeing the incursion of the quality improvement agenda. Our Clinical Audit Team has been re-purposed and our budget re-appropriated to enable Quality Improvement
- I don't think Sir Liam Donaldson has had any impact on reinvigorating audit...who did he think would take this forward
- I feel that clinical audit was trying to be phased out and replaced with QI. Now it seems that people are understanding that audit is a tool to do QI
- I feel that the importance of local clinical audit within my organisation has increased and there has been more investment into a audit management system. Since the announcement that there would be a change within National Audit to be more inclusive of independent sector involvement, we are looking forward to being able to participate
- I find NCA more beneficial at the moment. As involvement is mandated, we are able to use this to elicit engagement from clinical staff and trust board show more interest

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

- I have concerns that the QI focus is fast pushing CA off the quality improvement agenda . I worry that CA will cease to exit in the not too distant future
- I started in CA in 2015 so I don't know if by then it had already ben re-invigorated or not
- I think some clinicians are very enthusiastic about local audit and using it to make improvements. I don't feel national audits have the same effect
- I think that clinical audit is adversely affected by the amount of variation in how trusts are managing the relationship between QI and clinical audit (gauged by chat at regional network mtg). Junior doctors in our trust seem to have jumped onto the QI bandwagon but are submitting projects that are not true QI or good audits.
- Service evaluations appear to be on the increase, meaning a decrease in the number of clinical audits [I've just checked the last 3 full years at my Trust and percentage of audit is still significantly higher (avg 69%) but with slight decrease year-on-year]
- I think the key with keeping audit relevant going forward is to link it to Quality Improvement Methodology. QIPs are the "in" thing at the moment, so many people ignore audit, but it is actually a practical and logical starting point for many QIPs. I feel the focus in now on improvement, so we need to make sure that reinvigoration of clinical audit is centered around audit for improvement. Some National Audits seem to be taking a step in the right direction by making data more accessible, so this can feed in to local QIPs in a timely manner, but there is still more work to do. Local audits are often still done by Junior Drs to meet their portfolio needs, without the follow through to embed improvement due to the short time they are on rotation
- I would say there has been a slow improvement of the profile of clinical audit since 2007 and I think it is gaining momentum but I'm not sure I would say its been re-invigorated. I would say that there still needs to be more emphasis on promoting the importance of clinical audit and the benefits to patient care
- In our board there is a really good volume of quality clinical audit projects, however we do have a dedicated clinical audit support team, which helps enable this, but the drive from staff is still very much there to carry out audits
- In our organisation we have worked hard to reinvigorate our local clinical audits and encourage a quality improvement approach to projects
- In Urgent and Emergency Care within the Primary Care Sector, more emphasis is being made on reassuring patients and commissioners that company's have a quality staff group, working towards high standards of care for the patients, involving patients in Local Audits and promoting positivity regarding audit. The Audit Departments are now being seen as a positive step on gaining accreditation with commissioning bodies, outstanding with the CQC and the main achievement, the trust of all patients in delivery high standards of care
- It is a useful tool if carried out properly. To do that is has to be resourced
- It needs to be higher priority, I think it is sometimes seen as more workload rather than the useful tool it can be because of the amount of audit there is. It isn't effective if it is rushed to get onto the next one
- It's all in the name if we stopped name "audit" and started " VTE QI", "Adult Asthma QI" this would change people's perception and behaviour. Data would be still collected but AFTER a change has been implemented instead of before

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

- It's not a good year to make comparisons on due to the COVID situation and the catch up work to as some of the audits are delayed
- Keen to explore alignment to QI more readily
- Leadership and direction
- Local audit was being re-invigorated but that all fell by the wayside when HQIP became a National Audit Quango, and lost sight of 50% of its purpose. HQIP should lead, but when Trust see that HQIP does not actively drive and promote local audit, then Trust think is not a priority and move the audit staff into down banded National audit Admin role. The direct opposite to what Nick Black. Due to this i have moved to a semi private role in an NHS provider, as I genuinely do expect my role and wage to demise over the next decade. I never wanted to leave the NHS, but i feel clinical audit teams are less valued now than in 2007.
- HQIP did achieve re-invigoration, but it has undone all the good work it had done. CASC has delivered a more sustainable re-invigoration of Clinical Audit. If HQIP promoted the values and importance of CASC more, I expect this would drive a more proactive message into Trust board on the fact local audit is still just as important. However, if you started in a clinical audit job today new and went to the HQIP website, you would think it was a government website just for national audits. (Much in the same way the NICE website is for guidelines). Thanks goodness for CASC and lets hope HQIP finds its way back
- Local audits have more investment of the staff as they are more interested in the area they have chosen to audit. Not sure if there has been any reinvigoration though.
- More audit
- More financial investment. Also my Trust purchased a QI database with no consultation with the clinical audit department, which I felt made no sense
- National driver to support alignment of CA as an Improvement Tool and vehicle to continuous QI
- Needs to be mandatory part of the role of registered health professionals and doctors
- No meaningful changes can happen unless actioned fully and re-audits are performed
- NQICAN structure needs to reviewed to ensure everyone is represented and not just a chosen few
- Over the last few years I have witnessed a shift towards a more QI/Transformation focus in the NHS. Both in terms of jobs and structure. Clinical audit is becoming the poor relation or second cousin of "QI" and we are losing good staff to higher paid jobs in more QI focussed roles
- Reinvigorated as in there are more national audit requirements
- Reinvigoration is down to the leads and the drive the clinical audit department has within the organisation
- The issue is having the staff to complete the audits in a timely manner
- The lines between clinical audit and quality improvement programmes have blurred significantly. The quality of projects remain within the clinical audit arena (standards based) rather than QI projects
- The pandemic has made it possible to really look at what is important to do and reduced the data beast element in our trust
- The promotion of QI over audits has made it difficult to get people to engage with audits
- There has been no changes. I knew it was said but I am still waiting, rather concerning this form is asking if it has been achieved. What has actually been done so far? I would really like to know!

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

- There was a lot of noise, not sure the outcome could be considered achieved
- We have considerable staffing and resource challenges and therefore audit becomes less of a priority when this is the case, a lot of national audits were stood down at the start of the pandemic and all were stood back up at the same time adding considerable pressures when we were already stretched, so more coordination between national audits as to when they are delivered
- We need to focus more on how effectively we use the information we gathered from an audit. Design clinical systems to support clinical audit and record keeping this will reduce the burden of data collection and submission.

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