

Clinical Audit Today

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October 2008

Editorial: All Aboard the Reinvigoration Express

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Welcome to the first edition of *Clinical Audit Today*, the new quarterly journal that aims to keep you fully up-to-date with current clinical audit activity taking place across the UK. The journal is produced by the Clinical Audit Support Centre (CASC) and we hope that, in time, it will become a valuable part of the clinical governance landscape. Although clinical audit is an established discipline utilised by many healthcare professionals, there are few opportunities for those involved in audit to publish their good work and share it with the wider community. *Clinical Audit Today* will change that and it is hoped that the new journal will feature a wide range of local and national projects as well as healthy debate and discussion on all things clinical audit related. CASC actively encourage contributions from all disciplines and sectors and we hope that the journal will feature a rich diversity of audit-related work.

2008 seems the perfect time to launch *Clinical Audit Today* given all the recent changes taking place in the world of audit. Many of us are now coming to terms with new arrangements for the National Clinical Audit and Patients' Outcomes Programme, plus the National Clinical Audit Advisory Group and Healthcare Quality Improvement Partnership are both starting to take shape. The Department of Health have conducted a survey of clinical audit activity and there have been a number of regional events to help raise awareness of important changes. Add into the mix: revalidation, the Darzi Review and opportunities to link audit with the commissioning agenda and it is clear that clinical audit is undergoing unprecedented change not previously seen since medical audit was introduced almost 20 years ago. The Chief Medical Officer demanded that clinical audit be reinvigorated and this process is clearly underway. Those who dislike change and new beginnings need to remain on the platform, for those of us who welcome the challenge of new opportunities, it is time to board the reinvigoration express!

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HQIP

Healthcare Quality
Improvement Partnership

The New Voice in Healthcare Quality

By Robin Burgess, Chief Executive Officer of HQIP

When the Department of Health decided that responsibility for the national clinical audit programme should move from the Healthcare Commission, it seemed obvious to many that its new home should be with the clinical professions working in partnership with patient organisations. Dame Carol Black, Chairman of the Academy of Medical Royal Colleges, Peter Carter, General Secretary of the Royal College of Nursing and David Pink, Chief Executive Officer of the Long-term Conditions Alliance, shared this view. Their organisations came together as a consortium that, after a competitive tendering process, was awarded the contract to reinvigorate clinical audit in England.

The Healthcare Quality Improvement Partnership (HQIP) was set up in April 2008 with a board comprising nominees from the partner organisations. Its remit is to manage and develop the programme of national clinical audit and to promote clinical audit in local services.

HQIP has been established to support and enable a culture of quality improvement throughout health services.

From our base as a consortium of three organisations, we truly represent healthcare professionals and those organisations that act on behalf of patients and service users in order to improve outcomes.

Standards of clinical care are best set by professional bodies working with patients and service users. Only in this way will quality measurement be the engine that drives improvement in practice. And only if healthcare professionals are at the centre will we generate the meaningful and complete information needed to make this a reality.

HQIP is a non-profit making organisation and is not a regulatory body; our goal is to help healthcare professionals measure the quality of their work on behalf of the patients they serve.

At the outset our focus will be on clinical audit, but over time we will become involved in other areas of quality improvement. Quality is the touchstone of the health service, and HQIP is ideally placed to support the drive towards embedding quality in everything it does.

HQIP has three core roles, which give our immediate priorities, to:

- Manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP). The staff who managed this programme at the Healthcare Commission have moved across to HQIP to lead this work, ensuring continuity for the current national audit programme. Over time new audits will be added, and we will do our best to ensure that the contracted audits enable participating local services to improve care as well as providing a national picture of practice.

- Support and enable clinical audit staff in NHS trusts. As well as promoting involvement in the national audits, we will build competence, capacity and support for teams to run effective local audits that result in improved practice on the ground. To support this we will build the concept of audit as a profession, marked by validated training, set standards and defined, clear roles – all with a local, regional and national support structure. Central to this will be the creation and development of the National Clinical Audit Forum (NCAF) – an initiative that will bring people together by interest to share and exchange good practice and channel views to the centre.

- Promote clinical audit to all healthcare professionals. We will explore, with the accrediting bodies for each area, how audit can be made a required and essential part of how professionals are accredited or revalidated, thus making participation in audit a requirement from commissioners and subject to effective scrutiny from regulators. HQIP's role is to ensure that audit is always present as a measure of service quality and contributes to achievement of improvement in outcomes. HQIP will work with professional organisations and the Department of Health as they define how new systems will operate, offering advice and guidance as to how participation in audit is assessed as part of accreditation and revalidation.

It's a challenging agenda and there is a lot to be done. HQIP is new and is still recruiting. Over the next few months we will strive to be visible, communicating that we are here and that quality improvement matters. We will form partnerships and effective alliances with many stakeholders and, above all, we will work collaboratively.

We welcome views from anyone involved in audit about how we work. Watch out for our new website, launched in October, which will set out the ways we want you to get involved. The first step is to get listed in our new database of audit and audit professionals. If you are involved in clinical audit, get in touch via communications@hqip.org.uk

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A GP's Perspective on Comparing and Contrasting the Usefulness of Clinical Audit Verses Significant Event Audit

By Dr David Shepherd, GP at Saffron Group Practice, Leicester

Formal Definitions of Clinical Audit and Significant Event Audit

"Clinical Audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery."
Principles for Best Practice in Clinical Audit, 2002

"Significant Event Audit is a process in which individual episodes are analysed, in a systematic and detailed way to ascertain what can be learnt about the overall quality of care, and to indicate changes that might lead to future improvements."
Professor Mike Pringle, 1995

Clinical Audit and Significant Event Audit defined by Dr Shepherd

"Clinical Audit is the cyclical process of defining clinical criteria and standards, measuring performance against them, acting to improve quality and re-measuring."

"Significant Event Audit is an irregular process of picking up adverse events or near misses and learning from them."

What do GPs mean by 'useful'?

GPs are pragmatists by necessity and generally detest things they can't see the point of - particularly when imposed upon them from outside! And despite the bash-the-GP propaganda, they do usually have the best interests of their patients at heart so something that is useful to GPs will have realisable, practicable benefits for patients. It is something that does make a difference in the here and now without lots of form filling.

Potentially therefore audit could meet this definition of 'useful' for GPs but there are a number of pitfalls which affect significant event audit and clinical audit in different ways.

GPs may be pragmatists but they can also become very defensive when they feel challenged, particularly if they have come through the sort of perfectionist, high pressure training experience that is infused with the (false) myth of doctor unassailability. Any form of audit in this context may well be rejected as 'not useful' when it really challenges an unrealistic rigid self-perception.

To be useful, any audit has to come with a culture that is appropriate. Therefore it does need clinical leadership, someone who is prepared to give permission to discuss problems by being willing to bring their own significant events or expose their

own failures to meet clinical audit standards. There must be a culture which accepts that audit is about understanding why systems almost inevitably (mal)function as they do rather than trying to preserve the myth of medical perfectionism. The only apportionment of blame should be on the blame culture itself for stultifying genuine learning. Thus neither form of audit is useful in the wrong culture; indeed they are pointless.

Given that the environment is suited to audit, in that it recognises the inevitability that human systems will not always deliver perfect care and that it is usually inappropriate to focus the reasons for this onto individuals, what are the pros and cons of significant event audit and clinical audit for GPs?

Significant event audit lends itself well to clinicians' propensity to chat about clinical issues. Hardly a coffee break goes by without a discussion of something that would pass for a significant event. It is well suited to group and team discussion. The trick is to put the systematic processes in place to capture, discuss and act on this information. Useful, but only with the relevant organisation.

With clinical audit the organisation comes first and this is often the biggest hurdle. In recent years the Quality and Outcomes Framework has made a form of clinical audit more systematic and more accessible. This has undoubtedly brought a greater understanding to most practices of their populations and how well they are doing but there has been a cost. There has been a loss of locally available expertise in developing meaningful audits of topics that either go deeper or address local priorities.

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A GP's Perspective...continued

For the best care both types of audit can make a significant contribution. (see box 1) They are synergistic. Good clinical audit will minimise the Significant in significant event audit because good results in clinical audit require the kind of effective organisation that reduces significant events.

BOX 1: Clinical and Significant Event Audit Compared

Significant Event Audit

Random events

Reactive to events

Learning from experience

Comparing care with what shouldn't happen

About detecting Rumsfeld's unknown unknowns

Clinical Audit

Systematic analysis

Anticipatory

Learning from analysis

Comparing care with what should happen

Detecting known unknowns

So both are useful but significant event audit requires less initial input and gels with our tendency to find fault. But you can't rely on significant event audit to guarantee minimum standards, which can only be objectively demonstrated by clinical audit. Clinical audit is more useful as a guarantor of regular care, significant event audit tackles the bits one hadn't thought of.

Even if the culture and the organisation are right, there is no guarantee of effective audit. Both kinds need another resource that is generally systematically under-emphasised in the NHS; protected

time to analyse, time to prepare to change and the spare capacity to do so. It remains to be seen if the new emphasis on clinical audit nationally will be matched by realistic support.

Journal content disclaimer

Please be aware that the views of all authors who appear in Clinical Audit Today are not necessarily those of the Clinical Audit Support Centre Ltd.

New Guidance Launched to improve Patient Safety in General Practice

On 2nd October 2008, the National Patient Safety Agency (NPSA) launched new guidance for general practice teams enabling them to learn from patient safety incidents and "near misses". The new Significant Event Audit (SEA) guidance aims to improve the quality and safety of patient care in general practice.

The NPSA have developed two documents – a quick guide to conducting SEA and a full guidance document for primary care teams. Mike Pringle (Professor of General Practice University of Nottingham) and Paul Bowie (Associate Adviser in Patient Safety NHS Education for Scotland) have authored the guides. Speaking about the guidance, Professor Mike Pringle, University of Nottingham, said: "SEA is an established and effective quality assurance method in general practice. It helps to improve patients' experience, care and outcomes by facilitating learning from experience and will be part of GP revalidation. This guidance will help encourage and inform existing and new users of SEA."

Both guides are now available direct from the NPSA website visit: www.npsa.nhs.uk

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Involving Patients in Clinical Audit: How are we doing in 2008?

When it comes to involving patients in clinical audit work, there are two definitive statements that can be made. First, we know that patients should be directly involved in clinical audit activity. There are many documents that tell us we have to engage with patients, indeed as far back as 1994 the Department of Health identified in the policy document 'The Evolution of Clinical Audit'¹ that healthcare organisations should 'develop a mechanism for patient/carer input to clinical audit processes'. More recently, the Kennedy Report² made it clear that public involvement in the NHS must be embedded in its structures and who would argue that a publicly funded healthcare system should not actively engage its patients in making sure the care it delivers meets best practice? The second point to make is that although clinical audit has existed for almost twenty years, only a handful of organisations are effectively involving their patients in clinical audit work.

Few studies have looked at patient involvement in clinical audit, but those that have indicate that patients are rarely engaged in the clinical audit process. Kelson and Redpath (1996)³ found that only 8% of Medical Audit Advisory Groups involved patients in audit, with 19% of hospitals involving patients in audit activity. A more recent study by Jane Moore (2008)⁴ did find that patients were being involved in audit via user forums/councils and audit committees, but the report identified many barriers to effective public engagement in the audit process, including: lack of time/resources, financial constraints, staff inertia, etc.

In 2008, the Clinical Audit Support Centre were invited to take part in a number of regional reinvigoration events taking place across the country and we were asked to examine ways of

effectively engaging patients in the audit process. This provided us with the ideal opportunity to engage with the clinical audit community and 66 healthcare professionals (mostly clinical audit staff) kindly completed a short survey.

The results of the survey backed up the work of Kelson, Redpath and Moore and suggested that few organisations actively involve patients in clinical audit work. For example, only 9% of respondents to the survey stated that involving patients in audit is currently a high priority for them (65% stated it was a low priority). In many ways this does not come as a surprise and it is likely that audit staff and teams are concentrating on the delivery of local and national projects, training, developing audit strategies and programmes, etc rather than turning their attention to the difficult area of patient involvement in audit.

Many respondents to the survey were frank and honest, stating that they don't involve patients in audit and have no plans to do so in the future. Others noted that they indirectly involve patients in clinical audit via questionnaires and surveys, but few involve patients more directly in the clinical audit process.

When asked to identify barriers to involving patients in audit, we were overwhelmed with responses, ranging from traditional answers such as "lack of time/resources, no financial support, no facility to train patients, etc" to interesting responses "patients don't want to participate, it isn't possible to get a representative group of patients together, we have concerns re: confidentiality arrangements" to more blunt reasoning "we don't need patients telling us what to audit"!

The survey did identify some areas of good work and two respondents (3%) felt that they were undertaking very good work in comparison to others in this area. Examples of good practices included a number of teams using patient advocates to help select audits, design projects, review audit results and help suggest changes. Other teams worked with patients to conduct unbiased patient interviews as part of audit projects and one organisation invited patients to organise and run a clinical audit event. Overall, it is clear that most audit professionals struggle to effectively engage patients in the clinical audit process. Perhaps one respondent to the survey summed up the current situation in 2008 by stating... "delivering a good audit programme is hard enough... getting effective patient involvement in audit would be the icing on the cake".

The full report looking at patient involvement in audit will be available from the Clinical Audit Support Centre early in 2009.

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CAPRI: A Vehicle for User Involvement in Clinical Audit

By **Terry Matthews, Jacky Mason, Liesl Skelding-Millar**
Calderdale and Huddersfield NHS Foundation Trust

AIMS AND OBJECTIVES

- Describe the logistics involved in researching and developing patient involvement in clinical audit and the impact of setting up a patient panel on the clinical audit department.
- Explain how the Clinical Audit Patient Representative Initiative (CAPRI) was set up within an acute Trust setting and highlight what is involved.
- Highlight the results CAPRI has had around the Trust to date, as well as future plans to develop the initiative further.
- Share knowledge gained with clinical audit teams in other acute Trusts.

METHODS

One way of involving patients in service development is through clinical audit. Most NHS Trust clinical audit departments have tried to incorporate service users into their clinical audit programme, however this seems to be limited to patient satisfaction surveys. A handful of Trusts have tried to take user involvement to another level by involving service users in the day to day running of audits, e.g. questionnaire design, data collection.

The National Clinical Audit Conference in 2004 was the catalyst for our CAPRI project. It gave us food for thought and over the next two years we attended various PPI events gathering information. We knew what we wanted but were not sure how to go about it.

In particular, we asked advice from North Bristol NHS Trust and Sheffield PCT (formerly known as Sheffield South West PCT). From attending conferences and meetings with other Trusts, the aims became clear but the process was not. In August 2005, we carried out a one-off audit project involving service users. The project was successful but it had taken a long time due to recruitment difficulties.

In May 2006 we set up a working party, which included a patient representative, to look into the feasibility of having a patient panel at the Trust. We looked at logistical issues such as recruitment, financial implications, a training package, confidentiality and the structure and process of how it would work. Other issues researched were CRB checks, confidentiality, terms of reference, volunteer agreements, expenses and time involved and the effect it would have on the workload of our audit department.

In June 2006 we met with the Trust PPI Co-ordinator and took our proposal to the Trust Clinical Governance Board who gave us the approval we needed to take things forward. We then developed a training package which we trialled in October 2006. The audience consisted of staff members and patients; the key factor was that the audience had little or no experience of clinical audit. The training package covered five areas; history and background of clinical audit, the clinical audit cycle and process, getting started with an audit project, changing practice and information on the CAPRI, their role and confidentiality.



RESULTS

- The training package in October 2006 was well received; participants stated that it was informative and pitched at the right level.
- In March 2007, we presented at a 'Sharing Good Practice' regional conference in York and generated interest.
- To encourage staff to think about PPI, the clinical audit project plan was amended to include a tick box asking the clinician to consider patient representative involvement in the audit project.
- We started small within Cancer Services, as these service users tend to be in the healthcare system a long time and want to 'give something back'.
- Four CAPRI projects have been completed so far and four are currently ongoing with four more due to start. We have expanded into other directorates and divisions within the Trust.
- We have recruited eight CAPRI members to date and intend to expand to twelve by the end of 2009.

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CAPRI:...continued

The main benefit of having CAPRI is that we are involving patients at the heart of service development, which was one of the key actions identified from our Healthcare Commission inspection.

We have presented the work around CAPRI at the Regional Clinical Effectiveness Conference in Wakefield in November 2007 and also at the Clinical Audit National Conference in February 2008, giving working examples of problems / obstacles encountered and how we resolved them.

As CAPRI has now been up and running for a while, we held a CAPRI seminar in October 2008 which audit teams from acute Trusts from all over the country were invited to attend and learn from our experiences. We aim to share useful and relevant information on implementing a patient panel with the audit community and NHS organisations.

TOP TIPS for setting up your own patient panel

- Start small
- Need dedicated working group
- Get a champion from amongst clinicians (if possible)
- Be clear what you want from CAPRI member when designing volunteer and confidentiality forms
- COMMUNICATION! – on all levels
- Don't be afraid to take your time – get frequent feedback from managers and your colleagues
- Don't give up!

We would like to thank the following for their help and advice in setting up the patient panel: Chris Purvis, North Bristol NHS Trust, Emma Challans, Sheffield PCT (formerly known as Sheffield South West PCT), Warrington PCT, North Tees PCT, United Bristol Health Care NHS Trust Training Booklets, Audit in Primary Care – Ashton, Leigh and Wigan Group, North Tees and Hartlepool Clinical Audit Workshop Resources, Cleveland Medical Audit Advisory Group, Newcastle Medical Audit Advisory Group and Langbaugh Primary Care Trust Clinical Effectiveness Resources.

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.

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Five Top Tips for Re-invigorating Clinical Audit

Louise Hazelwood and Lorna Beard previously worked in clinical audit before both deciding to leave the vocation early in 2008. This article gives their viewpoint on how they would like to see clinical audit reinvigorated.



Louise Hazelwood

I worked in clinical audit and governance for 15 years and during that time saw both good and bad clinical audit taking place across the NHS. I left the NHS to find new fulfilment in a counselling career, which, I am pleased to say, is flourishing. But what might have tempted me to stay in the world of clinical audit? As the Department of Health sets in place its plans for reinvigorating clinical audit, these are my top tips for success.

Firstly, give local audit the resources and priority recognition it deserves. National audits have a place but, with the advent of practice-based commissioning and Foundation Trusts, there is a need to ensure that clinical audit is built in to the evaluation of new services. This requires priority time for clinicians to work with audit staff to design valid and reliable audits to ensure that patients are getting the best possible service provision.

National audits will never be able to cover the diversity of services that local providers wish to develop in response to local need.

Secondly, if Trusts are to be confident in the power of national audits to make a positive difference to the health of specific groups in their population, they need to feel real ownership of the audit projects in which they participate. They need to be able to influence the design of the audit tools so that they work effectively at Trust level. They need to have confidence in the audit data to be sure that the data are truly comparative and can be relied upon by Trusts to help them make informed decisions at a local level. Finally, they need to get timely feedback that is meaningful so that it stimulates local debate among clinicians on any changes needed to improve care.

Thirdly, stop the decline of clinical audit staff by ensuring that every Trust is well resourced with skilled and motivated individuals, empowered to influence audit at a local level. This will only happen if every Trust has dedicated audit champions, from among the healthcare professions, to inspire and lead their colleagues to participate in clinical audit. This would also serve to support the audit staff in being able to engage clinicians and maintain interest and momentum in audit projects.

Fourthly, give more reward and recognition to Trusts and Independent Contractors whose audits directly lead to improvements in care and service provision. The incentives to participate in audit need to enable time and energy to be available to

make necessary change happen. The focus must be on change and re-audit to demonstrate the effectiveness of clinical audit, as proof that it works when done well.

And finally, those at a national and regional, as well as local Trust Board level, who place requirements on organisations to undertake clinical audit, must first understand what audit is about. Clinical audit is not the panacea for all quality and risk issues. Expectations need to be realistic and clinical audit used appropriately, where there is a clear need and where the principles of sound clinical audit methodology can be applied, resulting in audits that do indeed lead to sustained improvements in care and service provision.



Lorna Beard

I came into clinical audit with a background as a quality auditor from a software house for Further and Higher Education software packages. This involved working to ISO 9001 and TickIT standards reviewing all the process documents, and auditing their use at the UK and Northern Ireland offices checking compliance. As the company had worked hard to gain its accreditation and understood what it meant, all staff worked hard to maintain this.

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Five Top Tips...continued

Quality auditing involves questioning frontline staff to see if the quality procedures that they have written and set in place are being followed. If not, action plans are drafted, corrections made and the area re-audited within a set timescale to see if processes are being followed correctly. Following an aggressive company takeover the office closed and so I turned to my old secretarial talents to find a temporary job at the local hospital. Within a couple of months this resulted in finding myself working in the clinical audit office and so began the next 8 years of my life.

Over the years I have been to many national and regional conferences and meetings about clinical audit, and it's fair to say that as opposed to the vigorous nature of quality auditing it appears to be approached very differently and given a different status by each NHS organisation. In some it appears to be of prime importance with large teams working with staff on properly planned and approved robust clinical audits, feeding the results to Board level, publishing them on websites, taking them to conferences and sharing them as best practice. In other areas it seems to be less important to the core organisation and departments are frequently understaffed with personnel striving to cope with the national, regional and local audits as well as often integrating other nationally set targets such as Standards for Better Health and Essence of Care.

Standing back and taking an outsider view on the situation if I could change or improve five things they would probably be as follows:

1) To ensure all staff from Executive level down, undertake training in clinical audit so they have a better understanding of what it is and what it can do when used properly to help an organisation to improve its services.

2) Comparing clinical audit to quality auditing I would like to see properly trained staff auditing processes and procedures within the NHS to ensure patient care is being delivered in a more consistent manner by everyone and if not, to put action plans and deadlines in place to achieve this. If one small process isn't followed when making for example a car, then it doesn't work properly. If a process isn't followed when operating on a patient then the result can easily be serious.

3) To see continued development, growth and support for regional networks. In some areas these are very strong and are a valuable resource to clinical staff, especially those working in isolation.

4) Develop increased opportunities for clinical audit staff to obtain qualifications in their field, to ensure that organisations have skilled staff able to drive change.

5) To see organisations sharing the results of clinical audits internally and especially to Executive level, thereby involving all levels and championing improvements in patient care.

In conclusion, having a consistent approach to reviewing criteria and standards, auditing with correctly trained staff, and analysing and using the results to implement change, will provide a wealth of valuable clinical data and enhance the reputation of the profession.

Signposting

Clinical Audit Today will advertise forthcoming events and conferences that should be of interest to those involved in clinical audit. The following events are taking place in the next six months:

Refresh Clinical Audit Day – 19th November 2008 (Trent Vineyard, Nottingham)

Refresh is part of the reinvigoration events being run across the country and is organised via the Trent Clinical Audit Support Network (CASNET). Speakers from CASC, HQIP, NICE and NCAAG. Free event to all those based in the East Midlands, email clinical.audit@nottinghamcity-pct.nhs.uk for more details

Risk and Patient Safety 2008 – 25/26 November (Church House, London)

The event includes 40 policy updates, case studies and interactive sessions, plus speakers from the National Patient Safety Foundations (USA). For more details visit www.healthcare-events.co.uk (quote CASC15 for a 15% discount)

The Art of Being Brilliant – 19th January 2009 (Leicester)

Andy Cope is an award winning author and trainer who proved to be the star speaker at both Audit 2020 conferences in 2007 and 2008. He has joined forces with CASC to run a day that will help audit professionals re-evaluate how they operate. Andy brings his expertise from outside the NHS to help reinvigorate audit within the NHS. For more details email info@clinicalauditsupport.com

Clinical Audit and Improvement – 4/5 February 2009 (Savoy Place, London)

Healthcare events annual audit event featuring NCAAG, HQIP, CASC, etc. Visit www.healthcare-events.co.uk (quote CASC15 for a 15% discount)