The state of clinical audit

9th annual survey
Final report
Published: May 2019
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 Medical Officer’s "reinvigoration of clinical audit" initiative that was launched in 2006. CASC devised the online survey and now have eight years of comparable data. CASC set up the online questionnaire via SurveyMonkey and various invites to participate were sent out in December 2018. For example, CASC sent an e-postcard at the start of December to a random selection of more than 1,000 individuals with an interest in clinical audit inviting them to participate. Thereafter the survey was widely publicised via a range of clinical audit resources, networks and services. The survey was open from the start of December to Christmas Eve 2018.

It should be noted that it is CASC policy to conduct all healthcare surveys in a confidential manner and respondents were not asked to provide any personally identifiable data. This year we amended the survey and withdrew a number of questions. We took this decision as it is clear that in 2018/19 staff time is precious and thus we wanted to reduce the burden on those completing the survey. Equally, by reducing the length of the survey we have been able to analyse the data and produce a more detailed report than ever before. Our interim report was published within six weeks of closing the survey and this final report has been released in May 2019. We firmly believe people value rapid feedback.

Response rate & respondents

Participation in the survey is optional. A total of 183 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 183 returns represents a small increase compared to the 175 received in 2017. It should be noted that this is the ninth consecutive year with more than 100 responses. The 183 returns in 2018 is second only to the 218 returns attained in 2016. We know of no comparable study of clinical audit that has the consistency, longevity or return rate of our survey.

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 183 respondents for section 1, the vast majority (60.2%) classified themselves as a 'clinical audit professional'. The majority of respondents (55.9%) had worked in clinical audit for 10 years or less. The majority of respondents stated that they worked in 'acute care' (56.5%). Throughout the survey the quality of responses was extremely high with very few missed answers.
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?
2 respondents did not answer Q1, leaving n=181:

<table>
<thead>
<tr>
<th>Classification</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical audit professional</td>
<td>109</td>
<td>60.2%</td>
</tr>
<tr>
<td>Clinical governance professional with responsibility for clinical audit</td>
<td>29</td>
<td>16.0%</td>
</tr>
<tr>
<td>Quality improvement professional with responsibility for clinical audit</td>
<td>25</td>
<td>13.8%</td>
</tr>
<tr>
<td>Clinician with interest/responsibility for clinical audit</td>
<td>6</td>
<td>3.3%</td>
</tr>
<tr>
<td>Other*</td>
<td>12</td>
<td>6.6%</td>
</tr>
</tbody>
</table>

*In most cases, those who answered 'other' to Q1, were clinical audit or governance professionals, but who clearly wanted to give precise details of their specific role. For full transparency we have listed all supplementary comments for those who answered Q1 'other'.

Q2 How long have you worked in clinical audit?
6 respondents marked this answer as 'not applicable', leaving n=177 who answered Q2:

<table>
<thead>
<tr>
<th>Experience</th>
<th>n</th>
<th>%</th>
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<tbody>
<tr>
<td>Less than 5 years</td>
<td>63</td>
<td>35.6%</td>
</tr>
<tr>
<td>6 to 10 years</td>
<td>36</td>
<td>20.3%</td>
</tr>
<tr>
<td>11 to 15 years</td>
<td>41</td>
<td>23.2%</td>
</tr>
<tr>
<td>16 years or more</td>
<td>37</td>
<td>20.9%</td>
</tr>
</tbody>
</table>

Q3 What sector do you work in?
6 respondents did not reply to this question, leaving n=177 who answered Q3:

<table>
<thead>
<tr>
<th>Sector</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care</td>
<td>100</td>
<td>56.5%</td>
</tr>
<tr>
<td>Ambulance</td>
<td>7</td>
<td>4.0%</td>
</tr>
<tr>
<td>Community</td>
<td>16</td>
<td>9.0%</td>
</tr>
<tr>
<td>Mental health</td>
<td>16</td>
<td>9.0%</td>
</tr>
<tr>
<td>Partnership (community and mental health)</td>
<td>13</td>
<td>7.3%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>2</td>
<td>1.1%</td>
</tr>
<tr>
<td>Other*</td>
<td>23</td>
<td>13.0%</td>
</tr>
</tbody>
</table>

*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'.
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?

2 respondents did not reply to this question, leaving n=181 who answered Q4:

<table>
<thead>
<tr>
<th>Response</th>
<th>Count (n)</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>More positive</td>
<td>81</td>
<td>44.8%</td>
</tr>
<tr>
<td>More negative</td>
<td>42</td>
<td>23.2%</td>
</tr>
<tr>
<td>Neither more positive/negative</td>
<td>58</td>
<td>32.0%</td>
</tr>
</tbody>
</table>

The graph below illustrates the significant changes in results over the last nine 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 significantly. Indeed, in both 2016 and 2017 more respondents answered 'more negative' than 'more positive'. In 2018 we can report a big swing back to 'more positive', as illustrated below. The 44.8% 'more positive' returns (for 2018) is the 3rd highest score in 9 surveys and the highest by a considerable margin since 2014.

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

3 respondents did not reply to this question, leaving n=180 who answered Q5:

<table>
<thead>
<tr>
<th>Response</th>
<th>Count (n)</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Yes</td>
<td>118</td>
<td>65.6%</td>
</tr>
<tr>
<td>No</td>
<td>62</td>
<td>34.4%</td>
</tr>
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</table>

65.6% of respondents for Q5 stated they intended to work in audit in 5 years. This represents a 10.3% improvement compared to 2017 and is the highest 'Yes' result since 2011.
Q6 Overall, how would you rate the quality of National Clinical Audit (NCA) projects that you have taken part in?

35 respondents did not answer Q6 (6 skipped the question while a further 29 marked the 'not applicable, I have not taken part in national audits' option). Results for the remaining 148 respondents are as follows:

- **Excellent**: 7 respondents (4.7%)
- **Good**: 49 respondents (33.1%)
- **Moderate**: 70 respondents (47.3%)
- **Poor**: 19 respondents (12.8%)
- **Very poor**: 3 respondents (2.0%)

The graph below shows for the ninth consecutive survey the highest response to this question (even when 'excellent' + 'good' and 'poor' + 'very poor' responses were grouped together) was 'moderate' (47.3%). Results are consistent across the eight years of data collection and this is shown by the fact that none of the lines on the graph have ever over-lapped. Results for 2018 convey a slight improvement when compared to 2017 (e.g. 'excellent' and 'good' up from 32.9% in 2017 to 37.8% in 2018).
Q7a 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: 35 respondents did not answer Q6, leaving 148 eligible to answer Q7a and Q7b. 114 of 148 respondents (77%) supplied an answer for Q7a. The following national clinical audits received 3 nominations or more:

- Sentinel Stroke National Audit Programme (SSNAP) 22
- National Emergency Laparotomy Audit (NELA) 15
- College of Emergency Medicine Audits (RCEM) 7
- Falls and Fragility Fracture Audit Programme (FFFAP) 7
- National Audit of Psychosis (NCAP) 6
- National Chronic Obstructive Pulmonary Disease Audit (COPD) 6
- Prescribing in Mental Health Services (POMH) 6
- National Hip Fracture Database 5
- Trauma Audit and Research Network (TARN) 3
- National Audit of Dementia 3

For the ninth consecutive survey, SSNAP received the most nominations in response to this question. Results for 2018 are similar to 2016/17 with NELA, RCEM, COPD, POMH and Hip Fracture Database, all featuring prominently. NCAP is the only significant new entry in the top 5. It should be noted that both POMH and RCEM audits feature in the above list, but it must be appreciated that these relate to a bundle of national audits projects.

Q7b What do you consider to be the least effective national clinical audit?
In total, 108 out of 148 respondents (73%) provided details of a national clinical audit in response to Q7b. NCAs receiving 3 nominations or more are listed below:

- Seven Day Service Audit 7
- National Diabetes Audit 7
- Myocardial Ischaemia National Audit Project (MINAP) 6
- National Clinical Audit of Anxiety and Depression 6
- National Clinical Audit of Psychosis (NCAP) 5
- Sentinel Stroke National Audit Programme (SSNAP) 4
- End of Life Care Audit 4

Historically, NCA’s that appear on the ‘least effective’ list show more variation when compared to the ‘most effective’ NCA list. However, in 2018 there is more consistency with 4 of 7 listed also appearing in 2017 (Seven Day Services Audit, National Diabetes Audit, MINAP and National Clinical Audit of Psychosis). It is noticeable that nominations are much more evenly spread in 2018 when compared to other years, with no NCA receiving more than 7 votes. It should be noted that the ‘Seven Day Service Audit’ is better known as the ‘National Seven Day Services National Self-Assessment Tool’ and the National Diabetes Audit relates to a bundle of audits that focus on patients with diabetes.
Q8a Within your current organisation, would you like more or less national clinical audits to be made available?

48 respondents did not answer Q8a. Of the remaining 135 respondents, the results were:

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<tbody>
<tr>
<td>More national clinical audits</td>
<td>52</td>
<td>38.5%</td>
</tr>
<tr>
<td>Less national clinical audits</td>
<td>83</td>
<td>61.5%</td>
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However, this result is crude and unsophisticated owing to the fact that it includes ALL 135 respondents, but without any appreciation of their workplace. For example, those working within Acute Care are expected to participate in a considerable number of mandatory NCAs. In comparison, those working in community care, mental health and ambulatory care only have access to a relatively small number of NCAs. Therefore, to provide more detailed insights, the results have been broken down further into smaller cohorts of respondents.

82 respondents (out of a possible 100) that stated they worked in acute care, answered Q8a and the results were as follows:

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<tbody>
<tr>
<td>More national clinical audits</td>
<td>25</td>
<td>30.5%</td>
</tr>
<tr>
<td>Less national clinical audits</td>
<td>57</td>
<td>69.5%</td>
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In comparison, the results for the 34 respondents (out of a possible 52) working in either mental health, community care or ambulatory care, were as follows:

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<tbody>
<tr>
<td>More national clinical audits</td>
<td>14</td>
<td>41.2%</td>
</tr>
<tr>
<td>Less national clinical audits</td>
<td>20</td>
<td>58.8%</td>
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By breaking down the data into small groups, we get a better picture of respondents current views towards national clinical audit.

Q8b Further comments in relation to National Clinical Audits

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

These three free-text questions have proved popular, with most survey respondents choosing to answer and provide feedback. Analysis of free-text is notoriously difficult to do, but we have provided our interpretation of the comments over the next few pages of this report. For the sake of transparency and considering that all comments were shared anonymously by members of the audit community, the appendix section of this report shows ALL comments as submitted so this allows readers of the report to review and interpret the data we have shared.
Q8b1 What is the single best attribute of National Clinical Audits?

A total of 118 free-text comments were submitted in response to this question. If we look back to Q6, 'overall, how would you rate the quality of National Clinical Audits (NCA) projects that you have taken part in?' 29 out of 183 total respondents answered 'not applicable - I have not taken part in national audits'. Therefore, it is reasonable to assume that the 118 comments in response to this question were submitted out of 154 eligible survey participants.

In terms of feedback, there was a variety of comments and you can read all of these (as submitted) in the appendix of this report. However, we have attempted to provide some useful feedback in terms of trying to identify key themes.

The main attribute identified by respondents, was that national clinical audits provide the opportunity to benchmark and compare practice. Indeed, in terms of a simple word count, 'benchmark' / 'benchmarked' or 'benchmarking' appeared in 37 separate free-text comments. Similarly, iterations of compare ('compared' / 'comparison' or 'comparative') appeared 20 times in 19 separate comments. 4 of the above comments included iterations of both 'benchmark' and 'compare'. Therefore, 52 respondents (out of 118 comments) cited the benefit of being able to benchmark / compare results and data via national audit.

In addition, 6 comments (5 unique to those already listed above) focused on the benefit of NCAs allowing those involved to gain a 'national picture' of care. Comments included: 'gives a national picture', 'get a national picture of current practice' and 'large data set collection for national picture', etc.

Purely looking at word count analysis, the next most popular word in response to this questions was iterations of 'improve' e.g. 'improving' / 'improvement' which appeared 16 times across 15 different free-text submissions. Comments focusing on improvement tended to highlight that NCAs can improve patient care as per these examples: 'care and patient outcome improvement', 'improving patient care', 'lead staff into a structured improvement cycle', 'they ensure that improvements are made', 'to drive local improvement', 'creates a learning and improvement culture', etc.

Aside from the themes listed above, a relatively small number of respondents focused their attention on other elements of the NCA process. 7 free-text answers highlighted the benefit of NCAs measuring care against standards, as per comments such as: 'all trusts measured against the same standards', 'everyone working to the same standards'. On a similar theme and although we have not been able to attribute a numeric response, it is implied that some respondents to our survey like the fact that NCAs allow users to adopt the same set of audit tools and methodology, i.e. aiding consistency of delivery.

In response to this question: 'recommendations' appear 5 times and 'change' appears 4 times. In most respects, the use of these words link to the aforementioned comments that NCAs can deliver improvements in care. Finally, it should be noted that a small number of responses imply that NCAs help raise the profile of audit and are taken seriously at a local-level. Comments here included: 'raises the profile of audit in general', 'NCAs get the attention of senior staff' and 'national audits are given the full attention by the Medical Director', etc.
Q8b2 What one change would you make to improve National Clinical Audits?

A total of 114 free-text comments were submitted in response to this question. If we look back to Q6, 'overall, how would you rate the quality of National Clinical Audits (NCA) projects that you have taken part in?' 29 out of 183 total respondents answered 'not applicable - I have not taken part in national audits'. Therefore, it is reasonable to assume that the 114 comments in response to this question were submitted out of 154 eligible survey participants.

In terms of comparing the free-text to the previous question 'what is the single best attribute of national clinical audits', the results for this question are considerably more diverse and varied. We have attempted to identify a number of recurring key themes below, but we would encourage all readers of this report to examine the free-text comments in the appendix section to draw their own conclusions.

Two main themes emerged when analysing the free-text in response to how NCAs could be improved. The first relates to reporting and the need for this to be improved significantly. Indeed, the words 'report/s' and 'reporting' appeared 31 times across 25 separate comments. Most comments highlighted delays in NCAs publishing audit results and or reports: 'quicker reporting', 'quicker turnaround of reports', 'reports should be published much sooner', 'timely reporting', 'smart reporting', 'speedier reporting', 'shorter reporting times', 'get reports sooner', 'better reporting mechanisms', 'access to own hospital data rather than waiting for report months later', 'audit reports and action plans much sooner', etc.

In addition, although it is very difficult to quantify, the other main theme in response to this question is the burden and workload involved in undertaking NCAs. Comments here are very difficult to categorise as some respondents focus on the burden created by elements of a single national audit (e.g. data collection), while others see the wider national audit programme as too much work. A selection of comments highlights the level of feeling here that we calculate relates to 27 different comments: 'less burdensome, the amount of data collected is verging on unethical', 'less exhaustive data collection', 'reduce the data burden', 'they could all be smaller', 'less workload, most data collection forms could be pruned without losing value', 'lower the amount of audits', 'less but better quality national audits', etc.

Other themes were difficult to identify, but there were lots of comments relating to improving the wider methodology used by NCAs and there were a number of suggestions that local audit staff could be better utilised to improve NCAs. Comments included: 'get local audit staff more involved in the development of NCAs', 'ensure Clinical Audit Officers are on the committees who create these projects', 'local clinical audit staff actually involved in development and piloting', 'require that the questionnaire and website design be done and tested by experienced audit professionals', etc.

This section of the survey generated lots of suggestions for improvement and a few notable ones have been shared below: 'more relevance to services outside acute sector', 'include Northern Ireland in all national audits', 'align to national QI programmes, e.g. GIRFT', 'make them audits and build them into the QI framework', 'remove data returns from busy periods - no deadlines around December and January', 'simplify methodology and tools', 'technical guides more user friendly, including correct and valid exceptions', 'all national audit are accessible in one place - even if it's just [web]links', etc.
Q8b3 Within your organisation would you like more or less national clinical audits to be made available?

This question relates to Q8a, where you can find the numeric results relating to 135 respondents. The free-text question shown above was also asked with 106 comments received. Interestingly, compared to the other free-text questions specifically in relation to national clinical audit in this survey, the responses here were significantly longer and more detailed. All comments can be found in the appendix and we encourage those reading this report to review these and draw their own conclusions.

When undertaking analysis of responses to this question, we found it particularly difficult to identify common themes. However, we suggest that a number of trends emerged.

First, as per responses to Q8b2 a number of concerns were raised regarding the burden and workload involved in taking part in individual national clinical audit projects and the wider NCA programme. Comments include: 'already too many with cumbersome data collection requirements', 'reduce the burden of data collection', 'fewer and more focused... there is considerable burden supporting the 50 or more national audits', 'quantity of data collection could be reduced', 'smaller, focussed audits with less demands on time for our clinicians', 'tools are complex and requires a lot of time', 'many of the national audits are trying to cover too much', 'national audits tend to ask for more information than they need, cause large amounts of work', 'national clinical audits are massively time consuming', 'reduce the number and data collection burden', 'some national audits are a huge burden on clinical teams', 'data collection should be streamlined', 'there are currently a lot of audits with a lot of data collection', 'too long, now actually harming patients', 'we have too many NCAs to complete in the hospital. The workload is stopping us from undertaking important local projects', 'there needs to be quite a cull of them', etc.

In addition to the theme that NCAs are currently too burdensome, a significant number of respondents to this question also pointed out that the current NCA programme is not appropriately balanced, with most national audits focusing on acute care. Comments included: 'as a Mental Health Trust we get a handful of NCAs compared to Acute Trusts... this is unfair', 'hardly any are relevant to Mental Health Trusts', 'it would be useful to have more national clinical audits relating to Mental Health / Community Health', 'more that are applicable for community services', 'need more in community sector', 'currently the focus of these projects is skewed towards acute trusts', 'they're very acute focused. Few seem relevant to community care', 'would like to see more that focus on the community and social sector', etc.

Aside from these two themes, there are an array of other comments to review and assess. We encourage you to read all free-text comments via the appendix.
Q9 In your opinion, which are the more effective at improving patient care?
26 respondents did not answer, leaving n=157 for Q9:

Local clinical audit (121) 77.1%
National clinical audit (36) 22.9%

For the ninth consecutive survey, local clinical audit outscored national clinical audit by a significant margin. The result for 'local clinical audit' in 2018 is very similar to previous years, although it is the lowest percentage return since the survey commenced in 2010. As the bar-chart below demonstrates, the results have been consistent over nine surveys with results for local clinical audit remaining in a 10% band-width (low of 77.1% in 2018 and a high of 86.9% in 2012).

Q10 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?
29 respondents skipped this question, leaving n=154:

0% to 20% (38) 24.7%
21% to 40% (49) 31.8%
41% to 60% (44) 28.6%
61% to 80% (15) 9.7%
81% to 100% (8) 5.2%

We appreciate that there is subjectivity with Q10, e.g. some teams carry out full-scale re-audits, whereas others conducted targeted re-audits. The results for 2018 are very similar to those reported in previous years and identify there is scope to improve re-audit rates.
Q11 Over the last 12 months, how would you rate the level of patient involvement in clinical audits you have taken part in/facilitated?

27 respondents skipped this question, leaving n=156:

Good, patients are heavily involved in clinical audit (4) 2.6%
Average, patients are involved in some aspects of clinical audit (31) 19.9%
Poor, patients are rarely involved in clinical audit (121) 77.6%

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, one should note that the number of respondents rating patient involvement in clinical audit as ‘poor’ is continuing to rise year-on-year and reached a survey high of 77.6% in 2018.
Q12 Over the last 12 months, what change has there been in the way clinical audit is resourced in your organisation?

25 respondents skipped this question, leaving n=158:

More resources available to support clinical audit (32) 20.3%
Resources for clinical audit have not altered significantly (57) 36.1%
Less resources available to support clinical audit (69) 43.7%

As noted previously, one of the main reasons for setting up this survey in 2010 was to attain measurable data in relation to the ‘reinvigoration of local and national clinical audit’. The graph below highlights that since 2010 respondents are reporting that resources for clinical audit in their organisation have not altered dramatically.

However, after 8 consecutive surveys reporting very similar results, in 2018 we have seen a clear and positive shift. For the first time in 9 surveys those reporting that they have ‘more resources available to support clinical audit’ rated above 20%. Indeed, the 20.3% mark attained in 2018 is considerably greater than the all-time low reported in 2017 of just 6.7%. Moreover, if one compares the margin between those reporting ‘more’ and ‘less’ resources compared to 12 months ago, the 15.8% differential in 2018 (‘less’ = 36.1% and ‘more’ = 20.3%) is considerably better than the next closest result of 22.3%, achieved in 2012 (‘less’ = 39.3% and ‘more’ = 17.0%). That said, the band-width of results over time remains relatively narrow.
Q13a 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:
30 respondents did not answer this part of Q13a, leaving a total of n=153:

Yes, reinvigorated (29) 19.0%
Not sure (58) 37.9%
No, not reinvigorated (66) 43.1%

This question was first introduced into the survey in 2015 as this marked the tenth anniversary of Sir Liam Donaldson’s call to ‘reinvigorate’ clinical audit. The graph below illustrates the results for the last four surveys from 2015 to 2018:

Results show a remarkable level of consistency, although we accept that four surveys over three years represents a much smaller data-set compared to other questions in this survey. Although there is a small improvement of those reporting national clinical audit has been reinvigorated (up from 16.7% in 2017 to 19.0% in 2018), double that number of respondents state that national clinical audit has not been reinvigorated and this has been the case in each of the last three surveys from 2016-18.
Q13b 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:
27 respondents did not answer this part of Q13b, leaving a total of n=156:

Yes, reinvigorated (34) 21.8%
Not sure (46) 29.5%
No, not reinvigorated (76) 48.7%

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 four surveys from 2015 to 2018:

Results show a considerable level of consistency, although we again point out that four surveys over three years represents a much smaller data-set compared to other questions in this survey. Interestingly in 2018 the proportion of those reporting local audit has been reinvigorated jumped from 14.7% in 2017 to 21.8% in 2018. However, those reporting local audit had not been reinvigorated also increased in the same time period, from 45.6% in 2017 to 48.7% in 2018.
Q14 Do you have any additional comments you would like to make in relation to the reinvigoration of clinical audit?

This was the last question in the survey and 56 comments were submitted.

Given that this is a fairly open-ended question, it is no surprise that a fairly wide-range of free-text responses were received. That said, the theme that stands out above all others is comments linking clinical audit with quality improvement (QI). Indeed, of the 56 comments received, 25 (45%) included either the wording 'quality improvement' or the acronym 'QI', or both.

Comments in relation to quality improvement (from here on referred to as 'QI'), were both positive and negative, with others suggesting that there was a need for clarity on how clinical audit and QI should inter-link. Examples of negative comments include: 'audit seems to be the poor relation each time a new initiative comes up, e.g. QI', 'clinical audit is getting lost amongst other QI and NCAPOP activity', everyone is so focussed on the white elephant that is QI activity, that clinical audit is very much playing second fiddle, particularly local clinical audit', 'our Trust is investing in QI. They have somehow received the message that this will replace audit', 'I think QI has been the new buzz word and perhaps clinical audit has been overlooked at times', 'local audit is sometimes pushed to the background as QI projects are faster to undertake and have more support within out Trust', 'we must ensure that our clinical colleagues and senior managers realise that clinical audit is a QI tool', etc.

However, not all comments received that included QI were negative and some suggested that QI has had a positive impact on audit, as per these comments: 'aligning audit with the QI and clinical effectiveness agenda has helped in our organisation', 'I feel that the slight reinvigoration I detect is really the result of a merging / linking of audit and QI', 'more resource is now a possibility for local audit under the title QI', etc.

A number of comments suggested there was a need for more clarity in terms of how clinical audit and QI inter-relate and comments included: 'with the QI drive it needs to be clearer how clinical audit fits in', 'there is confusion and competition at all levels with the big push for QI, there is more work needed to clarify how these compliment and feed each other', 'need clearer guidelines on relationship between clinical audit and QI', 'confusion and duplication between separate clinical audit and QI Departments', 'confusion with the terminology of QI vs clinical audit - many think they are two separate things and don't see the connection', etc.

In addition to the comments relating to QI, there were a wide range of other comments and we invite you to examine these in the appendix section of this report in order to draw your own conclusions.
Section 3: Conclusions and limitations

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

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

The CASC Directors, consider that the results of this survey provide a highly accurate picture of the state of clinical audit in the UK at the time when the data was collected (December 2018). We acknowledge that there are some limitations and the response rate could be higher, but for nine surveys running (over eight years) we have received over 100 returns.

This report marks a significant change in the way we carried out the survey. Given the pressures that clinical audit and QI staff face, we significantly reduced the length of the survey. This saved respondents time and helped ensure that the response rate to all questions asked was high. Further, by reducing the amount of data collected, this helped ensure that CASC could analyse information more rapidly than in previous years.

This final report builds on the interim report published in February 2019 and the headline results shared via the CASC e-Newsletter and Twitter account in January 2019. In addition to this 43-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 9th 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 December 2018.

CASC conflicts of interest

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

Next steps and future plans

CASC will endeavour to share the finding of this survey as widely as possible. Indeed, at time of writing this report (May 2019) the findings have already been presented to the East of England (EECANN) and London (LQICAN) regional audit networks. We are happy to present to any of the regional networks (on request).

We will also send this report to key bodies tasked and funded to improve clinical audit: NHS England, HQIP, N-QI-CAN, etc.). We will be creating an enhanced podcast with slides and audio commentary to better explain the outputs of this survey and we also intend to generate more useful infographics. We will also share this report via the N-QI-CAN’s National Networking and Sharing Forum (NNSF) to allow feedback and further discussion. We intend to generate a short document recommending how national audits can be improved and we will run the survey again, for the 10th time, in December 2019.
How would you classify yourself?

- Clinical Audit and Compliance Officer
- Clinical audit professional with responsibility for quality improvement
- Clinical Audit Support
- Clinical Effectiveness Department Manager
- Clinical Governance professional with interest in audit [x 2 comments]
- Clinician with no responsibility for audit but sponsors audit
- Data analyst
- Frustrated Clinical Audit professional that knows she should actually be seen as a QI professional (which incorporates Clinical Audit)
- Information analyst. Ex clinical auditor with an interest in the subject
- Quality Improvement Professional without responsibility for audit
- Research & Clinical Audit Manager.

What sector do you work in?

- Commissioning Support Unit
- Corporate
- Health and Social Care for the entire jurisdiction
- Hospice [x 3 comments]
- Integrated Care Organisation
- Integrated Care Organisation - NHS Trust
- Medical Royal College
- National Audit
- NHS Integrated Care Organisation
- NHSBT
- Palliative care
- Private healthcare [x 2 comments]
- Professional body
- Quality and Safety [x 2 comments]
- Regulator
- SHA
- Social enterprise with community and mental health services
- Trust-wide
- Urgent Care Out of Hours.
What do you consider to be the most effective national clinical audit?

- ACQI cardiac arrest
- Adhoc audits that that come from a risk or problems within wards / Trust
- Adult Cardiac Surgery - NACSA
- All
- All have issues. SSNAP as quick turnaround of reports
- Am yet to come across one! Seems arduous to produce the data then have to wait months for a report
- An audit where the audit itself is not too large to burden clinical staff e.g. with sufficient numbers of patients.

Where improvement recommendations are at least moderately achievable and have a positive impact on the care and treatment of a lot of patients. And with re-audit at a suitable time

- Any one that reports data at a trust level and publishes within 6-9 months
- BAUS
- Benchmarking against other hospitals enabling informed patient choice
- BTS Asthma
- BTS audits, TARN
- BTS, CAP
- College of Emergency Medicine
- **COPD [x 2 comments]**
  - COPD - purely from a personal point of view as we have a very engaged proactive team of Intensivists who actively participate in the audit
  - COPD secondary care and NELA
- Currently the Ambulance national audits are not fit-for-purpose, only SSNAP seems to be working with services to improve the audit process
- Delays in publish of reports
- Difficult to consider all but I think an audit is most effective where the clinicians are engaged in the data and the outcomes and where the project office is helpful and have a good knowledge of the detail. For example, National Dementia Audit where clinicians are engaged and useful data has been used although is there a question of how many more years this is carried on as practice has now made huge steps forward
- Difficult to know at this point as 2 new mental health audits are still not complete first time through
- Early Intervention spotlight
- Enabling the Trust to benchmark against nation reports
- Falls
- Falls & Fragility Inpatient Audit
- FFFAP
- From a surgical division point of view (as I work for this division within a Trust) the NELA Audit and Bowel Cancer Audit
- Heart failure
- Heart Failure Audit
- Hip
- Hospital acquired VTE
- I am not sure
What do you consider to be the most effective national clinical audit?

- I am unsure about the effectiveness of any of the national audits, but probably the one that we get most out of currently is the Sentinel Stroke National Audit Programme (SSNAP)
- I do not have direct responsibility for all NCAs but we have seen improvement locally following participation in NELA
- I'm only really involved in the Early Intervention in Psychosis NCA. This is an 'ok' national audit. It feels like we are collecting 'repeat' data which is also collected in the metabolic monitoring CQUIN
- In line with current evidence and practice. That is easy to complete, and considerate for clinicians time
- Intermediate care / rehabilitation
- Maternity and Perinatal Audits
- MINAP or NHFD
- National Anaesthetic Audit Projects
- National Audit of Diabetic Foot Care
- National Audit of Intermediate Care
  - **National Audit of Psychosis [x 2 comments]**
  - National COPD audit
  - National Dementia Audit - user friendly, coloured coded reports with linked workshops. Also RCEM reports are informative
    - National Emergency Laparotomy Audit
    - National Hip Fracture Database
    - National Maternity and Perinatal Audit
    - National Out of Hospital Cardiac Arrest Audit
    - NCAP
    - NCEPOD
    - NCISH, NACEL, FALLS
    - NDA
  - **NELA [x 9 comments]**
    - NELA but as a tertiary centre, many audits are not applicable or don't fit us well
    - NELA, TARN
    - New ACQI development
    - NHFD
    - NHFD, NJR, NAIF
    - NHSBT Audits
    - NNAP
    - None
    - None of them - sample sizes are too large most teams just focus on data entry not on shared learning
    - None that I have participated in
    - Not applicable to Palliative care other than the Falls and fragility audit
    - Not sure
What do you consider to be the most effective national clinical audit?

- Not sure if they are any!
- Of the ones I do now, the CQUIN physical health audit run by the Royal College of Psychiatrists
- Only know about the specialties I cover so POMH
- Our EIP welcomed the NCAP Spotlight audit
- **POMH [x 3 comments]**
  - POMH-UK can actually run a decent NCA. Their reports are still a bit hard to extract your actual results from, but they do provide slide-sets. They're getting there. Leagues ahead of any of the dross pumped out by HQIP
- POMH-UK
- RCEM audits
- RCEM audits, but any can be made more effective if clinician buy-in obtained to report Trust performance within any audit including plans to address weaknesses identified
- Royal College of Emergency Medicine (RCEM) Audits
- Sepsis
- **SSNAP [x 15 comments]**
  - SSNAP. The effectiveness of the national audits to drive improvements locally varies significantly between the projects. The majority of projects are generally good, and most have improved over the past few years. However, a number still remain poor due to the quality of the standards, data collection, data reporting and frequency of the reporting
  - Stroke
  - Stroke is useful
  - TARN
  - The new RCEM audits
  - The NHS Benchmarking ones, Dementia
  - They are all only effective to the extent that they are acted on locally. I think both the COPD and Stroke audits are good though
  - Unable to determine, but the RCEM audits seem snappy, topical and timely. They also have re-run when there have been national issues
  - Unsure at the moment as too new in post so haven't had a lot of exposure
  - We have been interested in the Falls audit. We have our own audit programme at the hospice, some of the NHS audits are not relevant to us.
What do you consider to be the least effective national clinical audit?

- 7 Day Hospital Study
- **7 day service [x 2 comments]**
  - 7 day services - the methodology wasn't great e.g. the Surgical Division - General Surgery and Orthopaedics had a small number of patients included, it was not enough for the Division to form actions plans on. Clinicians find it hard to engage with this audit, as there is a lack of funding to cover 7 day services
- 7 Day Standards
- ACQI STEMI timings (MINAP) and Stroke timings (SSNAP)
- All audits are effective, as they show where improvements need to be made, and also where the trust is making the biggest impact in care
- All cardiology audits
- All registries, 7 day services
- All those that are 'on-going' and those that take too long to publish the results. Staff are tired of the on-going NCAs and many now see these as purely a data collection exercise. The longer the results take to be published the less interest we are able to generate for change and action planning
- **Anxiety and Depression Audit [x 4 comments]**
  - Anxiety and depression was particularly poor
  - Any of the self collected / report surgical audits where data is only available to the surgeons who participate
  - Any that are "databases!" Always feels that standards are designed from the data not before data collected...research?
  - Any that provides no recommendations and takes more than eighteen months from start to finish - hence too many to mention
  - Any that take over 2-3 years to produce reports
  - BTS
  - Can't think of any
  - Cancer Audits
  - Cardiology Audits
  - Delays in publish of reports
- **Dementia [x 2 comments]**
- **Diabetes Audit [x 2 comments]**
  - Diabetes in children
  - Difficult. Many are poorly designed and so don't enable or encourage local action on the back of the audit being performed. Chicken / egg
  - End of life national benchmarking
  - I do not know enough about all the audits to answer this
  - I don't know
- **IBD audit [x 2 comments]**
  - Its hard to pick just one
  - Majority
  - MBRRACE
What do you consider to be the least effective national clinical audit?

- MINAP [x 5 comments]
- N/A [x 3 comments]
- NABCOP
- NADIA Clinical Harms
- National audit of Care of End of Life
- National Audit of Intermediate Care
- National audits that do not bring any kind of improvement, but are just done
- National Cardiac Audits (NICOR audits)
- National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis
- National Diabetes [x 2 comments]
- National End of Life Audit
- National Prostate Cancer Audit
- National registries - NJR / Vascular
- National Stroke Audit
- NCAAD
- NCAP [x 2 comments]
  - NCAP and related versions
  - NCAP EIP Spotlight CQUIN element - sample size didn’t feel representative
  - NCEPOD children and young people mental health - data submitted in 2016 and still no report
  - NHSBT Maternal Anaemia - currently in progress but already major issues with the data collection form
  - NICOR - due to delay in the provision of data i.e. 2016/17 data available in Nov-18. This data cannot be used to drive local improvements due to the time between collection and reporting. NABCOP - due to the frequency of reporting, the accuracy of the data and hence the confidence of the local teams to use the data to drive improvements. BTS - the audit standards have not historically mapped to the data collected / reported. Therefore unable to use data to identify if best practice is met and therefore limited its use to drive improvement locally
  - NICOR - Heart failure, arrhythmia, angioplasty - takes far too long for reports to be published
  - NOD Audit
- None [x 5 comments]
  - None as all report too long after data collection to make meaningful actions from the findings
- Not sure [x 4 comments]
  - Not sure - they all seem to require a high time commitment to enter data, but then there is often a significant time lapse before any results are available, which makes it more difficult for us to keep services engaged and see where improvements can be made effectively
  - Not to single out one, but issues with many include: limited focus on community, limited option to upload data electronically, e.g SSNAP audit only supports acute to upload electronically, national audits not costed, £10k payment when only 6 audits are applicable to our clinical work
What do you consider to be the least effective national clinical audit?

- NPCA
- NPDA - the waiting time is very long between data submission and then awaiting the final report
- Ones that collect too much irrelevant data
- Ophthalmology
- Out of date methodology; not in line with QI approaches. Bulky and complicated data collection tools
- PICANET
- POMH
- Pretty much anything by HQIP. They seem to struggle with understanding what a clinical audit actually is. What they do is over-onerous, time and resource wasting bean-countery of the worst sort. Somebody please make them stop
- Registry ones and any that are just collecting data
- Same as last answer. I found the NACEL one particularly difficult as the questions were very geared towards secondary care, not community
- Slow reporting
- Sodium valproate
- Some continuous data submissions where RAG rating is the only comparison
- Some national audits have been going on for years with continuous data collection. For example MINAP has a huge dataset but as a non-interventional hospital we have only 5 or 6 measures to consider which is little return for the huge dataset required. Is the data collected for this and some of the registries required for research rather than audit? Should there be a limit to how many years the audit carries on in the same format, the improvements should be embedded or re-consider what is actually going on in practice
- Some of the NCEPOD
- SSNAP
- Stroke Care Bundle and 60, STEMI 150 since introduction of ARP
- TARN
- The End of Life audit by NHS benchmarking. How did they get that carer / relative part approved
- The national comparative audit of blood transfusion
- There has been more non audit work added via HQIP now which seem to be less effective in the sense that we don't see much out of it. Such as the 7 day service, the registries (IBD / Joint). These data collection tools are very data heavy / broad and don't leave time to effectively implant any plans
- Timeliness of related report
- To be truthful, the vast majority of audits are not aimed at community services - but acute hospitals - thus we participate in a very few despite the clinical topic being of relevance to out patient population
- Too many to mention
- Unable to determine. Effectiveness would relate to changes made in our trust but national audits don't have the tendency to do this in practicality
- Unknown
- Unsure.
What is the single best attribute of national clinical audits?

- A focus on improvement
- A well-publicised report with recommendations can cause a lot of impact and mobilise actions
- Ability to benchmark with other organisations
- Ability to compare
- Ability to compare our performance across the country and benchmark quality of care
- Ability to see where you are currently at with data (as with SSNAP)
- All trusts are measured against the same standards
- Allowing us to benchmark our performance nationally
- Allows comparison between local and national results
- Allows national comparison with other healthcare organisations
- Being able to benchmark against other trusts challenges the perception that we are doing as much as we can
- Being able to benchmark services against other similar services / organisations nationally
- Benchmarking against other trusts
- **Benchmarking [x 11 comments]**
  - Benchmarking against other organisations
  - Benchmarking against other trusts
  - Benchmarking and sharing of learning
  - Benchmarking if done well
  - Best practice for patients
  - Can drive effective practice much
  - Care and patient outcome improvement
  - Change can be suggested on a national level which allows for better equality in care
  - Clarity of evidence-based standards to measure local attainment by
  - Clear identification of the most important audit outcomes
  - Collaboration of UK Ambulance Trusts in supporting each other
  - Commitment
  - Comparative data
  - Comparison
  - Comparison against other trusts and national performance
  - Comparison of ‘National’ compliance, etc
  - Comparison with other trusts
  - Compliance better with national audits
  - Consistency
  - Decisions made about nation-wide services
  - Drive evidence-based practice - like the Sentinel Stroke Audit used to do, and MINAP did for many years
  - Enables local results to be benchmarked nationally so performance can be compared with similar organisations
  - Engagement
  - Everyone working towards the same standards, gets a good understanding of what is happening nationally, and where things require improvement
  - Excellent tool for benchmarking nationally and with local peers
What is the single best attribute of national clinical audits? [continued]

- Focus on current status of service provision
- Get a full picture of how you are performing right across the nation
- Gives national picture
- Guaranteed re-audit
- Helps to focus in on areas of good practice / areas for improvement
- Identify national practice and measure performance across NHS
- Improving patient care
- Improving patients care, improving practice
- In our organisation - raises the profile of audit in general
- Integration with NICE
- It aims to improve patient care, which is fundamental in the Clinical Audit programme
- It gives national picture so you are able to see how you should be performing
- It should be to benchmark against nationally agreed standards of best practice
- It shows trust achievements
- Large data set collection for national picture
- Leads staff into a STRUCTURED improvement cycle
- Live data and run charts!
- Multidisciplinary support

**National benchmarking [x 4 comments]**
- National benchmarking and recommendations
- National data comparison
- National overview of trends, themes, outcomes and management
- National standard data
- Nationally it brings around good press / advertisement of issues which will provoke thought and action at hospital levels
- NCAs get the attention of senior staff in our organisation so indirectly raise awareness of clinical audit work
- Out of hospital mortality when available
- Pooling data and knowledge from wider group
- Provides a national comparison which promotes improvement amongst Trusts
- Provides a structured way to collect and compare compliance with standards
- Providing national benchmarking
- 'Power' to focus Trust if not matching national performance
- See how other trusts perform and review if their systems / treatments result in better outcomes
- Seeing where we stand as a trust and how we compare
- Shows nationally how others are doing in that area and therefore creates a learning and improving culture
- Standardisation and to get a national picture of current practice - a good foundation for change
- Statutory nature means they are completed and within timescale. Where done well provides local data benchmarked against the national picture so you can see how the Trust is doing compared to others, where the audit is repeated also easier to identify improvements over time
What is the single best attribute of national clinical audits? [continued]

- That they allow evidence-based improvement to be undertaken
- The ability to benchmark and the overall recommendations
- The ability to identify Trusts that are struggling at any particular criteria
- The fact that staff tend to be more committed
- The fact that they are published online
- The final publication appears to be of interest to local commissioners who are keen to make comparisons with other service providers - that said there is often little of value / similarity to community service providers
- The national benchmarking and the one-page HQIP / CC reports [note: CC may mean CQC]
- The ones with CQC interest
- The organisation of them is usually very good
- The recommendations don't change from year to year
- The Trust compliance to key standards in national audits are given full attention by the Medical Director and Divisional Directors and Senior Clinicians and it is very useful to see how well be perform against other trusts and nationally
- The wide scope of data collection
- Their ability, if done well, to bring about change on a large scale across all trusts
- They are mandatory and the results are published which ensures participation and some resource for the project, although this is only just happening for some!
- They are useful for ensuring that provision of care and treatment is more equitable across different geographical areas and delivered to a high standard
- They combine data from multiple sites allowing a comparison to be made to ascertain how well we compare locally with other Trusts
- They enable Trust’s to benchmark against other similar providers
- They ensure that improvements are made
- They stop every once in a while
- To be able to benchmark against other Trusts
- To benchmark how we are doing compared to our partner organisations
- To drive local improvement. To achieve this audits must be designed to measure against agreed standards of best practice, whereby data collection is not overly burdensome, that have a high degree of data quality, that report at a frequency and granularity that can be used to drive local quality improvement, and where recommendations are made that assist Trusts to deliver best practice
- Tools already designed
- Trends and benchmarking data
- Unsure at present
- We find clinical engagement is our biggest issue
- Well thought out design
- When they provide Trust level data in a timely manner with clear charts and benchmarking
- When you have the correct engagement, the results from national audits can help in making changes within the organisation
- You can compare your trust with other trusts.
What one change would you make to improve national clinical audits?

- A reduced programme planned to run over 10 years
- A shorter time for data analysis and reporting would be of benefit. The results are published so late on that data collection has begun for the next round and the clinicians are not interested in reviewing old data
- Access to own hospital data rather than waiting for report months later. National reports to give own hospital results with national comparator. One place to access all National Audit results and comparators (? NHSI doing this)
- Accountability to change practice
- Align to national QI programmes e.g. GIRFT
- All should provide real-time reporting of compliance with standards / key performance indicators to support improvement
- Although not easy, a more consistent approach across the board. Some are snapshots, some on-going, some are manual where others need inputting
- Audit reports and action plans much sooner!
- Automate data collection
- Be more standardized
- Be much more rigorous in requiring Trusts to be clear on what they've made of the results, what they've done, and what impact it has made
- Better and more timely local data
- Better communication from some of the organisations overseeing the projects
- Better data collection methods
- Better quality data
- Better recommendations / support to make local improvements to standardise care nationally
- Better reporting mechanisms
- Better understanding and collaboration between national audit staff and local staff
- Cannot think of anything
- Clear relationship to guidelines
- Clinical Leads working with auditors rather than the other way round
- Coordinate with other national requirements
- Cut all those which provide no analysis regarding quality, or at least some benchmarking against like trusts
- Cut down on the number of bland recommendations
- Data collection tools
- Do away with all the additional questionnaires - staff, patients, relatives etc
- Easier to understand
- Ensure sample frames are realistic. More information prior to registration to ensure the organisation will benefit from taking part and ascertain whether or not the data required is easily obtained
- Ensure that Clinical Audit Officers are on the committees who create these projects, particularly when creating the audit tools
- Faster turnover of results
- Get local audit staff more involved in the development of NCAs
What one change would you make to improve national clinical audits? [continued]

- Get reports sooner
- Have better clinical markers
- HQIP and NHS England to listen. At a recent meeting it was obvious HQIP were not aware of the methodology for 2 quality account national projects
- I would like to see the national audits publish written responses online from each of the participating organisations - including a copy of their action plans where this is indicated as necessary by any poor results. The national audit organisers should allow organisations 3 months to send their responses after the date of publication
- Improved methodology i.e. they follow a clinical audit approach
- Include Northern Ireland in ALL national audits
- Insisting that analysis and the final report should be completed in three months of the closure of data collection, to make the results relevant and timely
- It would be beneficial to make the processes associated with data collection more standardised
- Lack of local site data
- Late requests for quick large scale and complex data, which can cause serious disruption to planned work
- Leaders at the top of projects who know their subject not analysts who do not understand the subject!
- Less burdensome. The amount of data collected is verging on unethical in terms of the amount of time are clinical staff are spending on some NCAs, e.g NCAP and Anxiety / Depression
- Less but better quality national audits with timely reporting and information at trust level
- Less exhaustive data collection, quicker turnaround on reports and more clear recommendations for improvement in care
- Less workload. Most data collection forms could be radically pruned without losing value. Many questions in NCAs are research-based and only seem to serve the agenda of the Royal College responsible for managing the NCA
- Lighten the load for data collection - fewer questions to answer
- Link all audit bodies together
- Local clinical audit staff actually involved in development and piloting
- Lower the amount of audits
- Make standards clear (i.e. clear criteria and target) for all national clinical audits
- Make them audits and build them into the QI framework
- Make them more available to non-NHS providers
- Make them stop for significantly longer i.e. until they could justify their existence beyond their wizard wheeze use as a means of keeping a bunch of doctors from the royal colleges of ooh fancy pants lah de dah on the gravy train for life, without a single man / woman jack of them having to demonstrate any noticeable knowledge or expertise in the field of clinical audit as a quality improvement methodology
- Making the audit tool shorter
- More clarity in audit sample parameters
- More consideration of the data fields for collection, shorter reporting times
- More focused and quicker results
- More involved in quality improvement and sustained changes
- More relevance to services outside of the acute sector
What one change would you make to improve national clinical audits? [continued]

- More robust and regular benchmarking to improve consistency of approach and the value of comparability
- More robust methodologies
- More time between audits to enable steps to enhance improvement to take place. NHS is large organisation, more audits do not mean better results as staff taking part in audits are taken away from patient care. Organisations need time to reflect what changes need to take place to improve practice
  - Much shorter
  - N/A
  - National audits don't seem to follow HQIP best practice guidance when it comes to clinical audit and I don't see any evidence that national audits directly involve patients. It would be beneficial to involve patients in the design and delivery of NCAs
  - None
  - Not sure
  - Please see answer above local / regional audits would be of more relevance there does not appear to be a complete clinical audit cycle including re-audit with clear actions following review of findings - I would always expect this standard within local audits (otherwise I would classify them as an audit or a survey i.e. not a clinical audit)
- Quicker reporting
- Quicker turnaround of reports
- Reduce the data burden
- Reduce the no. of national audits
- Reduce the number and overall size of the national audits to ensure they are less of a burden on clinical teams. This would also support the timely review of the outcomes and identification of improvements. National reports need to be simple!
  - Reduce the number of audits questions
  - Reduce the number of them
  - Reduce the number of them and change the 'reporting data' ones so that they don't feature as national audits
  - Reduced number of audits focused on acute care and reduced data sets
  - Remove data returns from busy periods - no deadlines around December and January months
  - Reports should be published much sooner after the data collection period - you often have to wait at least a year!
  - Reports to be released quicker and this could be analyzed quicker, recommendations would be implemented quicker etc.
  - Require that the questionnaire and website design be done and tested by experienced audit professionals who can see the potential data entry / data completion grey areas
  - Results available for current year earlier
  - Shift in focus to reflect the current health provision e.g. community / social
  - Shorter list of questions - need to be specific to a particular area / issue
  - Simplify methodology and tools and the way results and outcomes are presented
  - Smaller datasets, currently projects trawl for a wide range of information that seems to be used for research projects and not for the good of patients with complex mental health needs
  - Some need better online portals to access audit information and input data
  - Sorry............ Two things......... numbers / scale AND timely reporting
What one change would you make to improve national clinical audits? [continued]

- Speed up the process of publishing the reports
- Speedier reporting. Accurate aims, objectives and methodologies to be released in a timely manner before the audit has started to enable planning
- Speedier return on the national reports
- Stricter deadlines for publishing
- Suitable for the environment they are auditing e.g. community specific and not acute / secondary care tweaked
- Target at specific topics with minimal data set - focus on one thing at a time
- Technical guides more user friendly, including correct and valid exceptions. Smart Reporting - no reports have ever been published other than spreadsheets. Sampling - submitting a 100% of cases has a huge burden on the audit team whilst we are on paper
- That all national audits are accessible in one place - even if it's just links. There are some on HQIP and linked NCEPOD, then there is NHS Benchmarking and then all the Colleges. I can follow those up that are registered with HQIP but I always feel that I'm missing something
- The data input methods could be improved
- The poor running of the audit i.e. questions having to be changed as the audit is underway, poor communication when things are changed, errors on the portal, long time waiting for the results, results being difficult to read as working out how they have reached specific subsamples. I often feel that when I ring with questions they just react on the spot without any thought or diligence. I was infuriated by the poor analysis undertaken on the sodium valproate audit. They counted the information leaflets within medication boxes as patients being given information about their meds! When did that become acceptable!
- The size of the datasets
- The way they provide their information should be standardised to make national clinical audits more accessible and easier to participate in. If there was a generic template which they had to follow in terms of what information is made available and how this is published, it would make it easier to gain an understanding of the audit
- There are a lot of annual national audits now, perhaps Trusts should be asked for yearly feedback regarding any changes to the methodology / audit questions to get the best out of the audits
- There should be a financial incentive attached to all national audit in the form of best practise tariffs
- They could all be smaller!
- Time lag to reporting
- Time taken to provide local results and national report
- Timeliness and comparability
- Timeliness of feedback
- Timeliness of reporting. COPD is an audit where you can see trends immediately. This should be considered best practice
- Timeliness of reports - take too long to be published
- To create a one single database that connects each National audit to each Trust and Organisation (auditors); so that everyone has the same access as well as same issues to make a truer picture for the Trust. For example, in my Trust we have had issues where the Trust system and the Organisation's system are not completely compatible and therefore either struggle to enter data at all or data is 'lost' and therefore the figures do not reflect the true status
- To get your own data / results back so you can create recommendations for your own trust
What one change would you make to improve national clinical audits? [continued]

- To have less continuous audits and more meaningful data. Prompt publication of reports, there tends to be a delay in publication of reports and changes / improvements to the service may have already occurred. National audits are generally time consuming, medical and nursing staff often have to fit data collection, reviewing reports, action planning etc around their day to day workloads which often results in delays in meeting deadlines, responding to report finding and action planning at a local level.
- Would recommend less data fields and more rapid PDSA cycles which are able to demonstrate an improvement in patient outcomes which links to national and regional quality improvement initiatives.
Within your current organisation would you like more or less national clinical audits to be made available?

- A lot of the national audits are moving to continuous data collection and I personally feel that the project then becomes a data collection exercise rather than a meaningful audit where changes are made to the service to improve outcomes and patient care
- Actually, I'd like to keep to roughly the same number - and just work on improving the quality of these (i.e. the 'so-what' factor)
- Again, I'm not terribly involved in NCAs. I think they are good for benchmarking our Trust against other Trusts, nationally. But I often think the questions are not audit questions and are more for collecting demographic data. I don't tend to trust the results of NCAs because we often have a lot of clinicians collecting data (so as not to put too much pressure on one or two clinicians) and therefore confidence in the reliability goes out the window because everyone interprets the questions differently
- Already too many with cumbersome data collection requirements
- Although National Audits provide valuable data, it would be helpful to review the number or merge those where possible to reduce the burden of data collection. As part of a rationalisation it would be beneficial to more fully align the national audit programme with the NHSi GIRFT agenda to support systems QI as this programme matures
- Ambulance trusts need to have support in setting up Audits better HQIP audits with ambulance clinical focus can help as national audits are time and not clinically focused
- As a Mental Health Trust we get a handful of NCAs compared to Acute Trusts. Yet we pay the same £10K rebate. This is unfair. It is not that I want lots more NCAs as the ones we have are big, unwieldy and burdensome, but I feel that we Mental Health Trusts are being sold short. Too many NCAs focus on physical care. Mental Health deserve more, better quality NCAs
- As an acute provider we participate in over 50 national audits which is very excessive and difficult to manage
- As National Audits are mandatory, Trusts have to participate and undertake the audits. It is easier to get these audits done. With lower priority audits, it can be very challenging and hard work to get them undertaken and re-audited
- Bureaucratic
- But these need to be better quality and more concise than current Mental Health Audits
- But with relevant local data reports and improved data collection
- Despite my current issues with national audit, IF they were better planned, data collection 'limited' with timely reporting I would welcome more projects as national audit is easier to obtain clinician buy in into rather than local QI / audit and would also benchmark the Trust giving us a better focus for future work
- Due to the amount of national audits currently we cant keep on top of ensuring the reports have been digested, that people are thinking about our performance and that we are creating action plans and then delivering them
- Due to the nature of the organisation we are currently participating in 50+ national mandatory audits which is a big undertaking as many of them have and are going to continuous data collection
- Due to the time constraints and the amount of time the audits take to complete. I think the audit tools should be shared before registration so Trusts can decide whether there is any benefit of taking part
Within your current organisation would you like more or less national clinical audits to be made available? [continued]

- Fewer and more focussed. Perhaps with a programme planned for 10 years so that different specialty areas are reviewed. There is considerable burden supporting the 50 or more national audits and confidential enquiries and some governance / audit teams are struggling to support clinicians with data capture
- Hardly any are relevant to Mental Health Trusts and most seem to focus on hospital care. We need more, better quality Mental Health NCAs that are quick and easy to carry out. Current NCAs for Mental Health are huge and take up a lot of time
- Have less - go for quality over quantity. Workload
- I do wonder how effective the audits sometimes are in having an impact at a local level. Some of the National Audits sometimes feel like they are more in tune with a nice to have data collection exercise than an actual audit with a drive to improve patient care. The guidance for participation can also sometimes be unclear which often causes problems
- I think they are given more priority and the trust has to take notice of them and act on them because they are in the public domain (and sometimes linked to best practice tariffs). However we can't realistically carry out more national audits currently due to depleted resources
- If national bodies worked more collaboratively, with more sharing of information I think the quantity of data collection could be reduced with greater focus on the quality of data collection. Some bodies are very receptive to the changes they need to make for their stakeholders (i.e. TARN) but I think some are very reluctant to review process / policy / standards (ie SSNAP)
- If they were run by a body that gave even half a fig for actually improving quality of care, weren't almost exclusively acute focused, and took the trouble to adhere to basic principles of best practice in clinical audit, then I wouldn't mind so much. But they're not, they're mostly run by HQIP who are, "E. None of the above"
- In their current format I would say less, however there are some that are worthwhile are run well. The NNAP has well timed results, local reports and produces posters with local results - this makes it easier to engage with the clinical team and use the data as intended
- Insufficient time between audits to implement measures to improve performance
- It can be quite sheltered within a hospice environment, we don't tend to have much to do with national audits, unless invited. I was not even aware of all the audits which have been done within the NHS. There are audits we complete from Hospice UK, along with our own audits. I would like more information on the audits taking place within the NHS
- It depends on the organisation and what is required
- It helps to drive quality locally
- It is important to see how we compare to our peers
- It is incredibly difficult to get any level of clinical engagement with audits, schedule 1, 2, 3 or 4
- It would be useful to have more national clinical audits relating to mental health / community health but only if they are organised and conducted appropriately, following the audit cycle with methodologies and data collection tools which have been piloted and require no further changes during the data collection stage. Also, smaller, focused audits with less demands on time for our clinicians
- Just focus on risk gaps associated with trust, for example, if falls is an issue then do a falls national audit. If it's not then a local audit should be done in association with the national audit so standards can be adhered to
Within your current organisation would you like more or less national clinical audits to be made available? [continued]

- Local audits enable actions to be taken in a timely manner once data has been analysed
- Mandated audits seem to get more engagement
- Mandatory audits are those that get completed
- Many clinicians see it as not the best use of time. Tools are complex and require a lot of clinical time. Results do not have an impact
- Many of the national audits are trying to cover too much. The recommendations are extensive and year to year are often repetitive. They don't appear to lead to strong improvements in practice because they have to be repeated. It feels like any important messages are lost because they have been drowned in the volume of recommendations
- Many of those relevant to this tertiary trust are annual data collections with no pause for any improvement work to be conducted. When we download our data it rarely matches exactly what we submitted
- More and in relation to Palliative care
- More clinical relevant audits representing the changes in modern society
- More engagement with community services as this is the place people live and receive the greatest contact with health (and social) care professionals
- More national audits will lead to more benchmarks being set
- More support for local audits and QI projects required
- More that are applicable for community services
- More well designed national audits would be preferable to the many local audits that do not result in assurance / improvement which take place at present
- More, good quality, national clinical audits for community would be welcomed but at the moment they concentrate on acute or primary care. Those audits that do include aspects of care provided in the community are often not geared up to community and there are barriers to participation
- Most of the ones in existence seem to be vast data gathering exercises with no applicable recommendations, or even the venturing of an opinion on best practice. There needs to be quite a cull of them
- National Audit standards give an impetus to standards. The senior management take notice of frontline needs to satisfy the standards
- National audits should take priority and it give the opportunity to see how we are doing across the country and it would be good if once the audit is complete we can share good practice and ideas
- National audits tend to ask for more information than they need, cause large amounts of work. They take too long to do the analysis, maybe a year or even two years in some cases. The results can often be too national and not enough information about local performance
- National audits' topics don't always fit with the priorities of the Trust. The tools are very long and not all the collected data are relevant to the services. Also it takes too long a time for the national team to provide individual report with findings
- National Clinical Audits are massively time consuming, and I think on the whole we fail to close the loop by completing effective action plans. I acknowledge that this may be a local issue, however given that we have cut our clinical audit resources from our corporate team it's unlikely to improve, and therefore we should reduce the number of NCAs we participate in
Within your current organisation would you like more or less national clinical audits to be made available? [continued]

- National clinical audits often represent a heavy data burden on Trust's and often have a poor methodology. Some medical specialities have an over burden of clinical audits (e.g. respiratory audits this year)
- Need more in community sector
- Neither, we have five and that is enough to know as a department
- No more than the current amount
- No time to facilitate them all
- Numerous national clinical audits collecting same data variables.
- Only because they are increasingly burdensome, poorly focussed and badly designed. I'm happy to have more GOOD national audits...
- Personally I feel that the majority are just collecting data and not actually undertaking a clinical audit. Wouldn't it be more beneficial if more focus was spent on improving current service provision locally rather than paying to participate in something with little gains to be made?
- Poor quality projects, if methodologically improved then would be happier to take part in more. They have always been pseudo research projects for the Royal Colleges that run them and they remain so
- Private healthcare needs more exposure to national audits
- Random National audits can be confusing and not well thought out with changes made on the hoof. If national audits are mandatory they should have been well researched and the methodology is simple to follow and achievable
- Reduce number and data collection burden
- Resource requirements are overwhelming and the results come out too late to be useful
- Same old: big delays in results cause meaningless data dissemination. Due to the workload involved in addition to paying to subscribe, perhaps the mandate could be limited to audits being undertaken in specified times, structured methodology (consistency) and analysed locally and more timely. Perhaps then local results could be collated by national teams? This would give more meaningful dissemination and also a national picture?
- Simple capacity to collect data versus the likely benefit in terms of local improvement. However the move to making data collection automated from EPRs helps reduce the workload burden, if well planned and supporting near real time reporting of results instead of the significant delays in reporting we still experience
- Slow response times. Not tailored to our services. Commissioning organisation's priorities are not our priorities.

Broad data collection - not targeted at specific areas within the topic. Audit to see what's going on, i.e. service evaluation, not quality improvement

- Small amount more or keep the same, only if better quality than currently
- Smaller snapshot audits would be more achievable / realistic with the resources the NHS has available at this time
- So more local audits can be done
- Some more 'new topic' audits need to be introduced - possibly a two tier system, with quicker turnaround of audit cycles and report feedback (not have to wait 18 months for a report)
- Some national audits are a huge burden on clinical teams and require a lot of resource which just isn't available in the NHS
- Specific for community only - not any at the present time
- Take up a lot of resource and often the outcomes are not followed up
Within your current organisation would you like more or less national clinical audits to be made available? [continued]

- The burden of national clinical audits in the clinical areas (especially when they go from annual data collection to continuous data collection)
- The clinicians in the Trust struggle
- The effect of clinical audit programs on hospital staff awareness about so many things, the improvement they see by numbers
- The national audit programme should be focused on driving improvement on a select number of key priority topics across the patient pathway. Currently the focus of these projects is skewed towards acute trusts, rather than primary and community care because of the ease of data collection. As a health service we are moving towards a focus on prevention and keeping patients out of hospital - therefore the focus of the national audit programme and the drive to improve across the patient pathway needs to reflect this
- The programme of audit needs to take into account the increasing demands faced by the NHS, whether its the timing of data submission to avoid the winter pressures, the duplication of effort as Trusts are asked to provide an increasing amount of data to not only the national audits and confidential enquiries, but also by NHS England, NHS Improvement and our commissioners, the many conflicting priorities faced by our clinical teams, the reduction in time available to clinicians to contribute to these types of activities via their job plans, and the shrinking resource available to improvement teams
- The national clinical audits applicable to mental health services are of poor quality and simply collect too much data. Reporting is long winded and the data does not drive improvement at a local level. I do not want more of the same, change needs to happen by those who are the paymasters to the Royal Colleges running these pieces of work
- The number of continuous National Clinical Audits has meant less resource available on local topics issues. I agree that the current crop of national audits has improved significantly but there is still room for improvement especially in providing more real-time reporting against performance indicators. Resources have not increased to support the increase in data collection requirements and the increasing number of national audit and whilst we are still using paper records is still labour intensive
- The trust needs to strive to make improvements in patient care, and in order to achieve this the trust needs to know where those focus areas are
- There are currently a lot of audits with a lot of data collection. The outcomes of these audits should be regularly considered as to whether or not they should usefully continue. Consider some short term audits which might give insight into the current state of a pathway / condition to provide evidence for improvement programmes?
- There are no national mandated HQIP audits for Neurology and Dermatology
- There has been a significant increase in the number of continuous national audits in the past year or so and it has been increasingly challenging to source the required resources to enable participation in these
- There is a constant battle to complete these from the consultant perspective and will often fall on to the audit teams to assist a lot. From our perspective and from other trusts we have spoken to this takes a large toll on the audit department. This huge scale data collection often means that less local / more personalised audit work for hospitals will be carried out by clinicians. Its hard to get an action plan from national work within our trust. There is a significant time requirement for entering data into national audits, but often a long wait before results and findings are published, so sometimes this can feel out of date
Within your current organisation would you like more or less national clinical audits to be made available? [continued]

- Pressure on clinical teams is mounting, particularly with winter pressures, and having to collect large quantities of data for a national audit, especially qualitative information which can’t be gathered electronically, reduces the amount of clinical time we can give to patients
- There is too much burden created by data collection, so a smaller array of more strategic national audits would be beneficial
- They are currently poor quality pieces of work and should not be titled as clinical audits. If they were properly sustainable pieces of work I would be keen that our trust participated more
- They’re very acute focussed. Few seem relevant to community care or where they have a community element it seems they are designed/ run by someone who has no concept of community care. As such we get no meaningful information from them and participating is an expensive tick box exercise
- Time is taken over the collection of the data and this gives less time for local audits. National audit results only gives a national view and the recommendations are the same for every audit, patients receive better care if they see the specialist team and are admitted to the specialist ward etc. In the perfect hospital yes that will be great but with all year round pressures for beds, to get patients who need a bed admitted within 4 hours. I think it would be best to focus on local audit to try and make small changes at a local level
- To release more resources to concentrate on local priorities for audit and subsequent quality improvement work. National audits have provided very similar performance figures for years - some appear to have reached a peak level of performance - whilst others demonstrate a consistently poor level of performance but trusts do not have the resources to take action for improvement. Some elements of the ACQI timings measures are out of the control of Trusts and so it is not clear why their performance is measured against them. Timings statistics are not provided by ambulance Trusts but are obtained from national projects who in turn obtain the data from acute, receiving Trusts. Acute Trusts are not under the same obligations to provide the data in accordance with the ACQI submission timetable therefore the care bundle data and the timings often do not relate to the same cases/time period
- Too long. Now actually harming patients
- Too much burden with the move to continuous data collection- asthma, falls, COPD
- Tricky question, generally I think staff respond better to national audits because they know they have to do them but they are far more time consuming and not as satisfying as being able to produce a report fairly swiftly after data collection so on the whole I think less national audits might be better
- Until they are useful, they are just a waste of time and resource. Glad that, being in mental health, their burden isn’t too onerous, just costly
- We are moving away from clinical audit
- We are seeing an incremental increase of national audits per annum, with a number moving to continuous data collection and / or alignment with BPTs. Our administrative staffing resource, as with many NHS Trusts, is decreasing at the same time
Within your current organisation would you like more or less national clinical audits to be made available? [continued]

- We have too many NCAs to complete in the hospital. The workload is stopping us from undertaking important local projects that could improve patient care and safety. Year-after-year we keep reporting back that the burden is too great but no one seems to be listening. I would go as far as to say that patient care is being compromised by clinicians having to collect audit data rather than see patients. It is a good job the media don’t realise just how much time is wasted on national audits. If they did we would be front page news in the Daily Mail.
- We spend a huge amount of time collecting and submitting data for national audits. This places a lot of pressure on clinicians who are already under considerable clinical pressure. The data that comes back is sometimes only be presented at a trust level and can be quite old therefore losing its relevance. Results are not always presented in a way that is useful for trusts. We need audits that provide good quality data to make the data collection process beneficial. The aims and potential benefits from each of the audits needs to be clearly defined at the outset. Consider less mandatory audits and allow trusts and commissioners to identify those national audits which would provide the most beneficial to them. This would also allow better action planning and implementation of changes.
- We struggle to get buy in and meaningful actions. The amount of improvements we can make is outweighed by the struggle to get the audits completed.
- Where they are mandatory, clinicians will engage with them. They provide vital benchmarking across organisations.
- With National audits and CQUINS we have too many audits.
- Work in the independent sector and there are very few audits that private hospitals are eligible to participate in.
- Would like to see more that focus on the community and social sector. Require electronic upload and timely reporting that allows benchmarking like for like. Need information to be easily accessible and people available to answer questions. Need an easier way to review the list of National audits to find the few that are relevant to our service, this currently takes a lot of resource. £10k payment needs reviewing as community trusts access less audits.
Do you have any additional comments you would like to add in relation to the reinvigoration of clinical audit?

- Aligning audit with the QI and clinical effectiveness agenda has helped in our organisation, our annual clinical effectiveness showcase has also helped to raise the profile
- Audit is only effective if change is implemented, this is often be dependent on support being available at management levels and also in some instances on budgetary constraints. Clinicians need to see the benefits from submitting these data and this is not always the case
- Audit seems to be the ‘poor’ relation each time a new initiative come up i.e. Quality Improvement, Transformation etc.
- Audit should have a higher profile in terms of why it is carried out and the commitment to clinical audit. It is often seen as the poor relation of research (which of course comes with greater kudos and financial reward)
- Clinical audit feels like it has a ‘home’ in QI but in some organisations is in danger of being pushed out by PDSA / model for improvement
- Clinical audit is getting lost amongst other QI and NCAPOP activity. Much time now seems to go to collecting large amounts of data for national “audits” and registries that is collected for the purpose of pooling for use in research rather than quick and simple clinical audit
- Clinical audit is not valued in my organisation
- Confusion and duplication between separate Clinical Audit and Quality Improvement Departments. Clinical Audit if undertaken properly as a PDSA cycle has always led to improvement
- Confusion with terminology of Quality Improvement vs Clinical Audit - many people think they are two separate things and don’t see the connection - thus think they are required to do x2 the workload
- Define it. Define what would be required to say whether it has happened. We need guidelines to measure against!
- Everyone is so focused on the white elephant that is most QI activity, that clinical audit is very much playing second fiddle, particularly local clinical audit
- Focus on national audits has had a negative impact on local audit
- For national audits - they need to calm down - quality not quantity every time!
- I do not think that nationally there has been a reinvigoration of clinical audit, in particular local clinical audit. In some cases we have seen national audit redesigned to bring it more in line with QI methodology, but again this has had varied success due to the extra burden placed on staff in terms of data collection and hence data quality. Locally we have continued to enjoy a high degree of engagement with our local audit programmes, but again we are beginning to feel the strain on teams who have particularly heavy national audit requirements, and a growing dissatisfaction amongst some clinicians with some national audits who seek feedback from the clinical community but then this is not acted upon
- I don’t understand the relationship between NQICAN, HQIP and NHS England. Who is being paid to do what?
- I feel that the national clinical audit programme needs to be reviewed and major changes put in place in order to engage clinicians with this work. There also needs to be more money for resources directed at local clinical audit, as many HCP’s do not understand what makes a good clinical audit
- I love the strap-line ‘clinical audit - the original quality improvement methodology’, but it is easy to get parochial about Clinical Audit, instead of seeing it in the broader perspective of Quality Improvement and Clinical Effectiveness
Do you have any additional comments you would like to add in relation to the reinvigoration of clinical audit? [continued]

- I think any reinvigoration has been down to the Quality and Development Lead at the hospice
- I think audit is seen as find errors in practice and I think it should it should be marketed as improving patient care
- I think he [Liam Donaldson] is correct, it needs reinvigorating. We are pushing QI rather than Clinical Audit and the current programme for junior doctors doesn’t encourage re-audit. It feels like a tick-box exercise
- I think quality improvement has been the new buzz word, and perhaps clinical audit has been overlooked at times as a clinical improvement tool in it’s own right. However we are still as active as ever regarding participation in local and national audits. I think there is now a greater awareness in audit action plans, and recording actions to take and implementation of change, rather than just suggested recommendations
- I wasn't working in audit at the time so I don't have a pre / post comparison
- In our own Trust a new system [name of product withheld] has helped immensely!
- In relation to Q13a / b - I feel that the slight re-invigoration I detect is really the result of a merging / linking of audit and QI really - and the 'buzz' or greater interest around quality improvement has had a knock on effect
- It feels as though 'the reinvigoration of clinical audit' was a buzz / catchphrase 10 years ago that has been consigned to history. The investment in local audit via HQIP seems to have dried up. NQICAN now seem to be trying to support us local staff and their forum is vaguely useful (despite looking like something from the 1990s). But where has all the local funding gone? HQIP now seem to be a procurement agency. I can't remember seeing a HQIP member of staff in public for the past two to three years. They have gone from being the self-styled 'home of all things clinical audit' to a faceless organisation
- It is getting more support from senior leaders as they gain the realisation that the quality of review it provides can be exceptional but with resources being squeezed, it does not get the practical level of support from the service managers
- Just not enough time, so much done on goodwill
- Local audit is sometimes pushed to the background as QI projects are faster to undertake and have more support within our Trust. We are trying to join audit and QI approaches
- Local audits are undertaken mainly by medics that use this quality tool for their re-validation instead to improve patient care. Therefore this is used a tick-box exercise
- Local reinvigoration would benefit from more support from national level - to raise the profile and credibility of audit so that resources are more likely to be made available for QI work
- Lots of money spent on clinical audit in NHS but it is often mis-used. No real assessment undertaken about whether projects making a difference to patient care / offering value for money
- Make senior boards responsible for audits
- More resource is now a possibility for local audit under the title of 'quality improvement'
- My department has reduced from five full time members of staff to 2.5 FTE in 6 months. We have no capacity to re-invigorate clinical audit. Clinicians are overstretched and complain about the proportion of work they are already asked to do - despite being given time and extra pay to carry out audit work. When we have previously run education sessions / drop-in sessions / clinical audit awareness activity - we have received a total of 5 attendees for a Trust with over 11,000 employees
Do you have any additional comments you would like to add in relation to the reinvigoration of clinical audit? [continued]

- NCAPOP status of some projects has given us the 'lever' to get required 'buy-in', whether this can be deemed re-invigoration is open to debate!
- Need clearer guidelines on relationship between Clinical Audit and Quality Improvement
- Our department is being downsized, not deliberately but by a process of staff movement and re-shuffle of bands and hours worked. We are undertaking more work and trying to develop the quality of audit and its action planning
- Our team is transitioning whilst we are recruiting we have lost staff and had to halt progress I am optimistic for the future
- Our trust is investing in "Quality Improvement". They have somehow received the message that this will replace audit and are buying into this. We are trying to emphasis that audit is quality improvement, but as the project progresses I worry that audit will be become undermined and undervalued. It feels like we are on a frontier trying to defend audit
- Primary care is missing a trick. Need more clinical audit awareness and support in this area
- Still too many national audits for the Acute Sector, not enough for Primary Care, Social Care or Mental Health
- Thank you for re-sending me this survey. To be truthful I have not participated in it for a couple of years as I felt that the national clinical audit programme has little to offer those of us who work in the community. I hope you will appreciate my standpoint and look forward to hearing about future changes in direction
- The national audits should be more succinct and the data collection tool should be shorter
- The re-invigoration has not been noticed by those delivering it. Pressures have increased through less resource, more CQC impacts and constant restructuring
- The Royal Colleges never cared much for local clinical audit. Why would they: "I didn't spend a geological epoch qualifying to be a consultant to have some non-clinical pencil pilot tell me how to do my job!" etc. So they've had the scalpels out since about 2010 - ish? And hey presto! Loads of articles in the Lancet about how rubbish Clinical Audit is and the emergence of their pet project: QI - or: 'pretending you're doing something vaguely scientific and methodologically rigorous in the name of improving care so you can get your ARCP without having to deal with those dreadful oiks in the clinical audit team'. Don't get me wrong, QI is fine and great, but the docs didn't need to discredit clinical audit to the extent that there are now teams of Clinical Audit Officers on Band 5s being sidestepped by the appearance of emperor’s new methodology QI teams on Band 6s in the same trusts, which is a [expletive withheld] scandal
- The Trust Board and Executive Team need to support with and back clinical audits more. They should be CA champions themselves if we are to be able to get more and more colleagues to undertake audits and re-audits
- There is a general feeling that the relationship between audit and health care professionals / clinicians has broken down and so it is difficult to reinvigorate
- There is confusion and competition at all levels with the big push for Quality Improvement, there is more work needed to clarify how these compliment and feed each other
- There needs to be a re-brand. There is much emphasis on QI and the 'Model for Improvement' which, in essence, is a Clinical Audit cycle done quickly and then re-done a number of times. We must ensure that our clinical colleagues and senior managers realise that Clinical Audit is a QI tool
Do you have any additional comments you would like to add in relation to the reinvigoration of clinical audit? [continued]

- There seems to be less reinvigoration and more of a focus on changing clinical audit to "quality improvement"
- This was 11 years ago so not really relevant in 2018 – there was a reinvigoration but has gone backwards more recently
- This was nothing to do with any national push - purely due to a disinvestment, and then reinvestment, by the organisation
- We are moving towards other QI methodologies and will use the most appropriate tool for the job. Clinical audit is still our job title and I am involved in many local audits. (I realise that national audits are such a big thing to many, as reiterated by the many questions about them in this questionnaire). We now see the QI problem 'in the round' with an audit being the first round - more emphasis now on QI at the action stage. Is a refreshing a liberating way of working, freeing clinical audit to be one of many tools for quality improvement, rather than just a quality assurance straitjacket
- We need more audit support for hospices given the amazing work we do with often very sick and end of life care patients. As small teams we don't have the capacity or funding to have our own in-house clinical audit team. Audit is often the responsibility of one person who volunteers but who has many other roles to fulfil
- Where has HQIP support for local audit gone?
- With the Quality improvement ‘drive’ it needs to be clearer how clinical audit fits.