clinical audit
SUPPORT CENTRE

RAISING STANDARDS IN CLINICAL AUDIT

The State of clinical audit

Results of the December 2016 online survey

Report published August 2017

www.clinicalauditsupport.com

Background

Since December 2010 the Clinical Audit Support Centre (CASC) have conducted an annual survey aimed at healthcare staff with an interest in clinical audit. CASC introduced the survey to help measure the Chief Medial Officer's 'reinvigoration of clinical audit' initiative. CASC devised the online survey and now have seven years of comparable data. CASC set up the online questionnaire via Survey Monkey and various invites to participate were sent out in December 2016. 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 and services. The survey was open from the start of December to 24 December.

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.

CASC also aim to provide complete transparency when conducting the annual survey and view the results as belonging to the clinical audit community. With this in mind all comments received via the survey are included in the appendicies. Comments made by respondents have been left as they were submitted, unless there was an obvious spelling error or typo. Where the exact same comment has been received we have grouped these together.

Response rate

A total of 218 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 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 218 returns represents a small uplift on the 182 respondents in 2015 and a significant increase on the 101 returns received in 2014. This is the seventh consecutive year with more than 100 responses. We know of no comparable study of clinical audit in the UK that has the consistency, longevity or return rate of this survey.

The respondents

As stated above, minimal personal data was collected as part of the survey. Respondents were asked a number of broad demographic questions:

1) How would you classify yourself? (possible answers were 'clinical audit professional', 'clinical governance professional with responsibility for clinical audit', 'clinician with interest/responsibility for audit', 'quality improvement professional with responsibility for audit', or 'other').

2) How long have you worked in clinical audit? (possible answers were '1-5 years', '6-10 years', '11-15 years' and '16 years or more').

3) What sector do you work in? (possible answers were 'Acute Care', 'Ambulance Trust', 'Community Health', 'Mental Health', 'Primary Care', or 'other').

Of 218 respondents for question 1, the vast majority (57.3%) classified themselves as 'clinical audit professionals'. The majority of respondents (59.9%) had worked in clinical audit for 10 years or less. The majority of respondents stated that they worked in acute care (56.1%). Throughout the survey the quality of responses was high with very few missed answers noted.

Q1. How would you classify yourself?

All 218 respondents answered question 1:

Clinical audit professional	(125)	57.3%
Quality improvement professional with responsibility for audit	(36)	16.5%
Clinical governance professional with responsibility for audit	(33)	15.1%
Clinician with interest/responsibility for audit	(10)	4.6%
Other (see appendix 1)	(14)	6.4%

Q2. How long have you worked in clinical audit?

6 respondents did not answer Q3. Of the remaining 212:

1-5 years	(70)	33.0%
6-10 years	(57)	26.9%
11-15 years	(43)	20.3%
16 years or more	(42)	19.8%

Q3. What sector do you work in?

4 respondents did not answer Q3. Of the remaining 214:

Acute Care	(120)	56.1%
Ambulance Trust	(4)	1.9%
Community Health	(21)	9.8%
Mental Health	(27)	12.6%
Primary Care	(2)	0.9%
Other (see appendix 2)	(40)	18.7%

Please note, the second highest response to question 3 is 'other' (n=40) and appendix 2 provides full details. Analysis of the 'other' respondents shows that 19 included 'community' in their answer, 14 included 'mental health' in their answer, 4 included 'acute' in their answer, there were 5 answers with "hospice" denoted and 2 included 'commissioning' in their response.

Therefore, by revising the figures we can clarify that: 57.9% (n=124) of responses feature 'acute', 19.1% (n=41) of responses feature 'mental health' and 18.7

% (n=40) of responses feature 'community'.

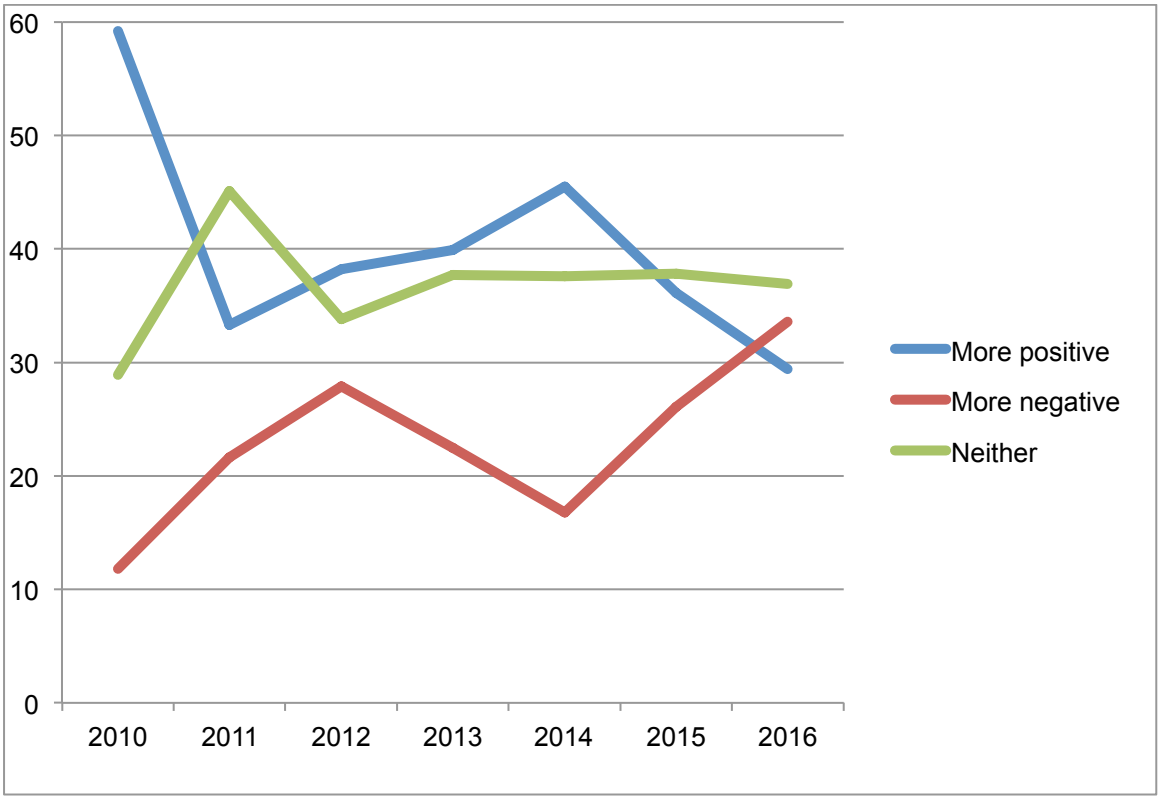
Results

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

4 respondents did not reply to question 4. Of the remaining 214 respondents:

More positive	(63)	29.4%
More negative	(72)	33.6%
Neither positive/negative	(79)	36.9%

Results for 2016 incorporate a 'landmark' moment in that for the first time since data was collected in 2010 the number of 'more negative' responses (33.6%) is higher than the number of 'more positive' responses (29.4%). While the proportion of 'neither' responses has remained consistent in recent years (between 37.8% and 36.9% in 2015/16), the proportion of 'more positive' responses has declined significantly from 59% in 2010. 2016 also marks the first time that less than 30% of respondents have answered 'more positive' to this question and the first time 'more negative' has exceeded 30%.



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

7 respondents did not answer Q5. Of the remaining 211:

Yes	(116)	55.0%
No	(95)	45.0%

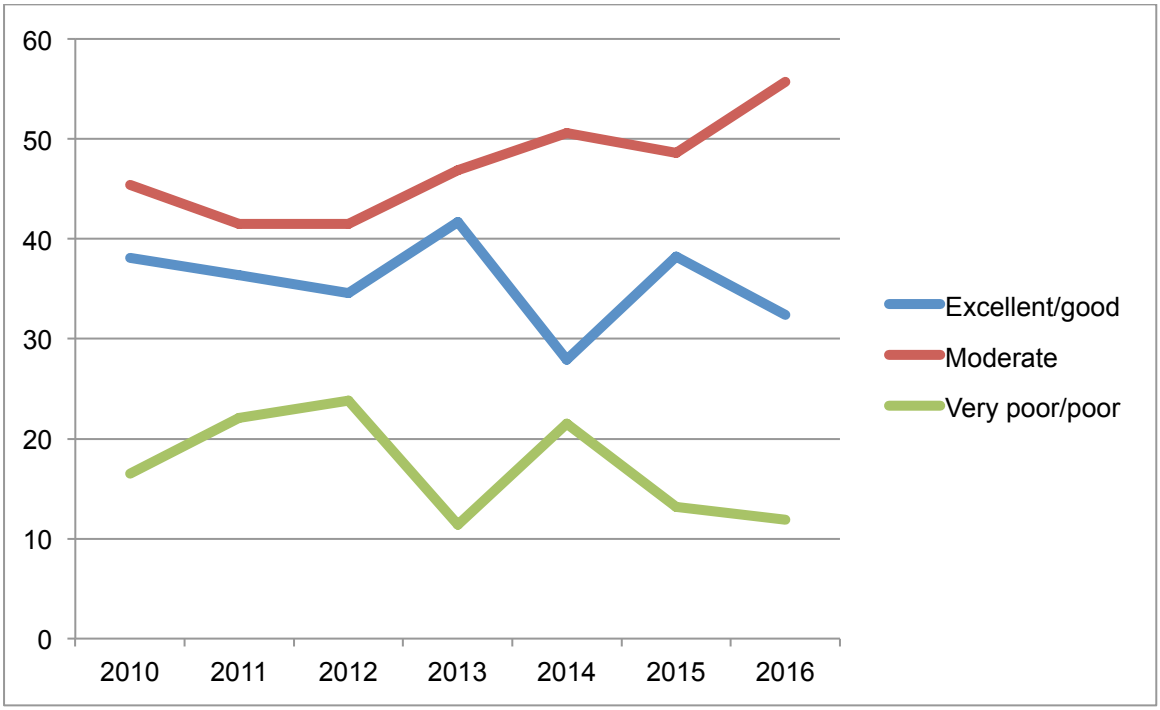
Results for 2016 represent the smallest proportion of respondents in the history of the survey (55%) to state that they still intend to work in clinical audit in 5 years. The first survey in 2010 resulted in 75% of respondents answering 'yes' to Q5.

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

42 respondents did not answer Q6. 4 skipped the question, while a further 38 marked the 'not applicable – I have not taken part in national audits' option. Results for the remaining 176 respondents are as follows:

Excellent	(8)	4.5%
Good	(49)	27.8%
Moderate	(98)	55.7%
Poor	(15)	8.5%
Very poor	(6)	3.4%

The chart below shows for the seventh consecutive year the highest response to this question (even when 'excellent' + 'good' and 'very poor' + 'poor' responses were grouped together) was 'moderate' (55.7%). Results are very consistent across the seven years of data collected although the rise in respondents rating NCA's as 'moderate' is noticeably higher than at any previous point.



Q7a. What do you consider to be the most effective national audit?

A total of 136 qualitative responses were received that named a national audit. A number of responses did not focus on a specific national audit project. For example, comments included: 'NA', 'none', 'not sure', etc. A small number of replies named more than one national audit, e.g. 'SSNAP/National Hip Fracture Audit/National Emergency Laparotomy Audit'. In the instances where multiple NCA's were identified, each named audit was allocated a single vote.

The following NCA's gained 3 votes or more:

Sentinel Stroke National Audit Programme (SSNAP)	29
National Emergency Laparotamy Audit (NELA)	15
Prescribing in Mental Health Services (POMH)	10*
College of Emergency Medicine Audits (CEM)	5*
MINAP (Myocardial Ischaemia National Audit Project)	4
UK Parkinson's Audit	3
National COPD Audit	3
National Hip Fractures Database	3
Neonatal Intensive Care	3

Once again, the results for this question show overwhelming support for the SSNAP audit. Indeed, SSNAP topped our poll for the seventh consecutive year. It is disappointing to note that in 2015 a total of 12 NCAs gained at least three votes via our survey but in 2016 this number declined to just 9. **It must be noted that both CEM and POMH audits feature in the list above, but it should be appreciated that these relate to a bundle of national clinical audits.*

Q7b. What do you consider to be the least effective national audit?

A total of 114 qualitative responses were received. A number of responses did not focus on a specific national audit project. For example, comments included: 'N/A', 'all', 'unknown', not sure', etc. A very small number of replies named more than one national audit, e.g. 'COPD or Head and Neck Cancer'. In the instances where multiple NCA's were identified, each named national audit was allocated a single vote.

The following NCA's gained at least 3 votes:

National Audit of Intermediate Care	9
National Diabetes Audit	6^
MINAP (Myocardial Ischaemia National Audit Project)	5
Sentinel Stroke National Audit Programme (SSNAP)	4
National Audit for Rheumatoid and Early Inflammatory Arthritis	3
National Head and Neck Cancer Audit	3
Seven Day Services Audit^	3

The results above show that respondents spread their votes widely in response to Q7b. Seven national audits gained three or more votes. The National Audit of Intermediate Care received the most votes (9) having ranked 3rd in 2015 with 5 votes. ^To clarify, the 'seven-day service audit' is better known as the 'National Seven Day Services National Self-Assessment Tool'.

^It must be noted the National Diabetes Audit features in the list above, but it should be appreciated that this relates to a bundle of national clinical audits that focus on patients with diabetes.

For information, a complete list of responses for questions 7a and 7b can be found in appendix 3 and 4.

Q8. In your opinion, which are the more effective at improving patient care?

28 respondents did not answer Q8. Of the remaining 190:

Local audits	(158)	83.2%
National audits	(32)	16.8%

For the seventh consecutive year, local audit outscored national audit by a considerable margin. The 2016 result of 83.2% for 'local audit' represents a small drop from the 84.3% figure reported in 2015.

Q9. How is clinical audit managed in your organisation (e.g. data entry/analysis)?

26 of the respondents did not answer question 9. The 192 respondents who completed the survey were asked to 'tick all responses that apply' so respondents were able to give multiple answers if they use a range of resources. We have listed all answers that identified by more than 10% of respondents:

Excel	(163)	84.9%	
Survey Monkey	(55)	28.6%	
Access	(48)	25.0%	
*Other	(45)	23.4%	(see appendix 5 for full details)
Formic	(25)	13.0%	
Snap	(25)	13.0%	
SPSS	(16)	13.0%	

Since the survey was established, Excel has consistently achieved a top result. However, the 84.9% result for 2016 is considerably less than the previous low of 89% in 2011). Prior to 2016, Access had always achieved the second place behind Excel, but for the first time since the survey started this is no longer the case. Indeed, the rise of respondents reporting they use SurveyMonkey has been exceptional. For the first three years of our survey from 2010-12 SurveyMonkey was not available and hence did not receive any votes. It is now placed above all other resources other than Excel in our list.

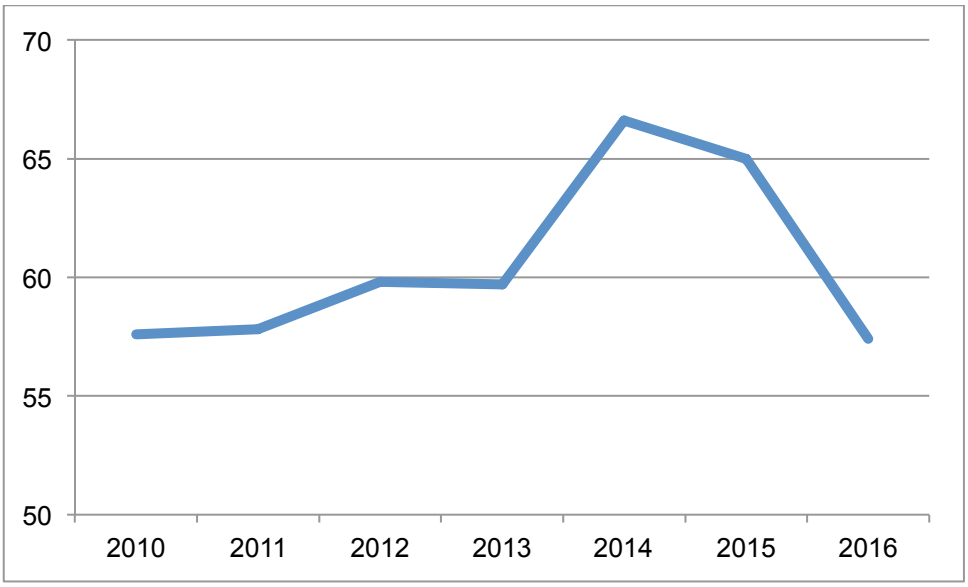
Q10. To your knowledge or best approximation, what proportion of local audits initiated in your organisation result in a re-audit being carried out?

28 respondents did not answer question 10. Of the remaining 190:

0-20%	(46)	24.2%
21-40%	(63)	33.2%
41-60%	(45)	23.7%
61-80%	(26)	13.7%
81-100%	(10)	5.3%

Results for question 10 remain remarkably consistent over the seven years that the survey has been carried out. The graph (overleaf) illustrates the combined percentages of respondents answering 0-20% and 21-40%. Over the course of

the survey this result has been in a 10% corridor from a low of 57.4% in 2016 to a high of 66.6% in 2014. It is good to a see steady decrease in those reporting a 0-40% re-audit rate over the last two years.



Q11. To your knowledge or best approximation, what proportion of local clinical audits initiated in your organisation result in a financial cost saving (after time spent conducting the audit project has also been deducted)?

64 respondents did not answer Q11. Of the remaining 154:

0-20%	(109)	70.8%
21-40%	(27)	17.5%
41-60%	(13)	8.4%
61-80%	(5)	3.3%
81-100%	(0)	0%

The results provided in relation to question 11 show remarkable consistency over the seven years of the survey. It is clear that very few local audits focus on financial cost savings.

Q12. Which of the following clinical audit resources do you use and how do you rate them?

A total of 187 respondents answered Q12. Each respondent could rate as many resources as they wanted to. The following list provides details of the resources that received the most responses:

HQIP website	(179)	95.7%
NICE website	(171)	91.4%
HQIP eBulletin	(169)	90.4%
Local/regional clinical audit meetings	(153)	81.8%
CASC eNews	(119)	63.6%
CASC website	(118)	63.1%
NQICAN website	(80)	42.8%

NAGCAE webpages on NHSE website	(61)	32.6%
Online journal of clinical audits	(56)	29.9%

As in previous years the resources provided by HQIP and NICE scored most highly in relation to this question. However, it is good to see an increase in those reporting that they access the CASC eNews (up from 53.6% in 2015 to 63.6% in 2016) and the NQICAN website (up from 36.1% in 2015 to 42.8% in 2016).

Ratings for clinical audit resources:

The table below ranks various resources in order of "usefulness". The results are not significantly different to those reported in previous years although it is good to see 'local/regional audit meetings' jumping from rank 6 to rank 2. However, this is in part due to two resources being removed from the results in 2016 as they are no longer in use or kept up-to-date, namely CASC's Clinical Audit Tools website and online journal.

Resource	Total replies	Not at all useful	Not useful	Average	Useful	Very Useful	Score*
CASC eNews	119	3	1	18	66	31	4.017
Local/regional audit meetings	153	5	5	31	59	53	3.980
CASC website	118	3	2	20	64	29	3.966
HQIP Bulletin	169	3	5	32	88	41	3.941
HQIP website	179	2	8	37	92	40	3.894
NICE website	171	0	5	48	89	29	3.871
NQICAN website	80	9	7	28	29	7	3.225
Online journal of clinical audits	56	2	4	26	22	2	3.321
NAGCAE webpages on DH website	61	10	6	28	16	1	2.951

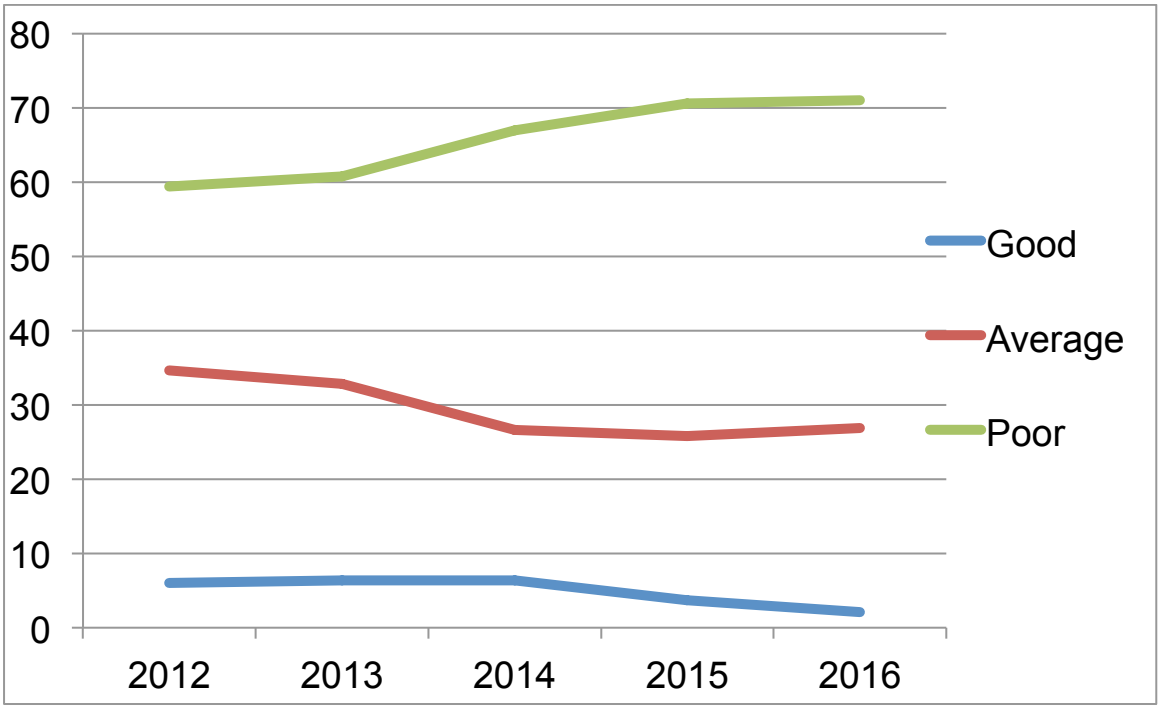
Please note: the score for each resource was calculated using the following formula: 5 points for a 'very useful' response, 4 for 'useful', 3 for 'average', 2 for 'not useful' and 1 for 'not useful at all'. Total scores were then divided by the number of replies for each resource to attain an overall rating score.

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

32 respondents did not answer Q13. Of the remaining 186:

Poor – patients are rarely involved in audit	(132)	71.0%
Average – patients are involved in some aspects of audit	(50)	26.9%
Good – patients are heavily involved in audit	(4)	2.2%

This question was introduced in the 2012 survey as CASC wanted to measure views on patient involvement in audit as this was first recommended by the Department of Health in 1994 and has been championed in recent years by the Healthcare Quality Improvement Partnership. Results from 2012-16 are shown in the graph overleaf and identify that year on year the proportion of respondents rating patient involvement in clinical audit as 'poor' continues to increase.

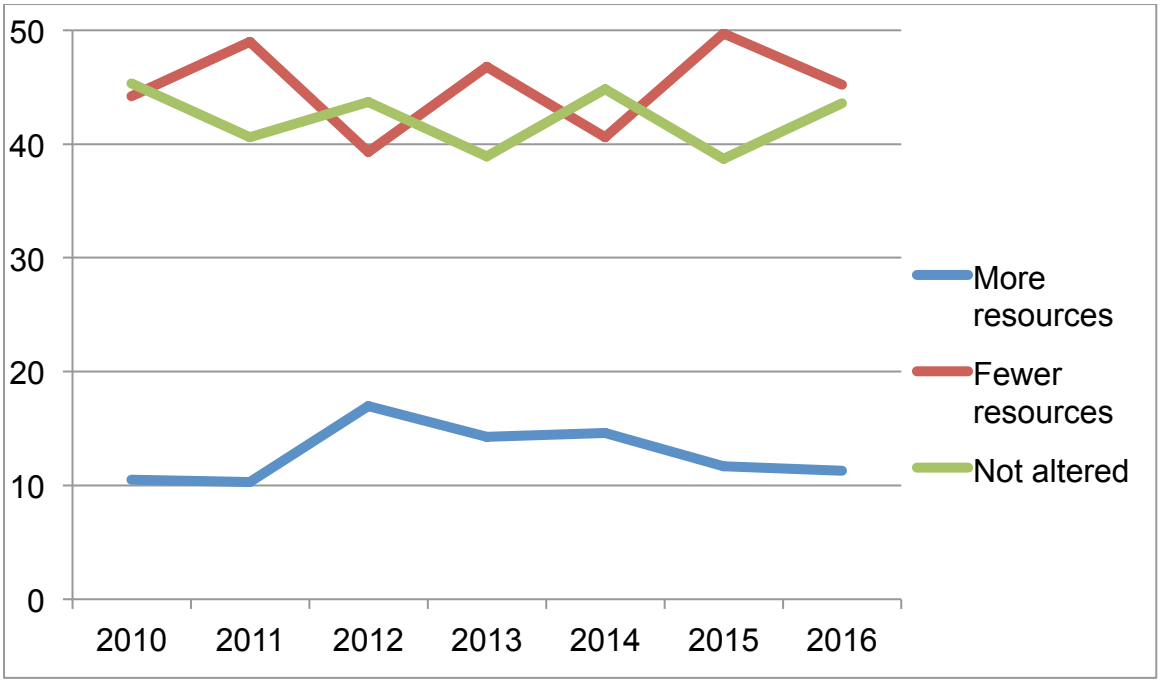


Q14. Over the last 12 months, what change has there been in the way clinical audit is resourced in your organisation?

32 respondents did not answer Q14. Of the remaining 186:

More resources available to support audit	(21)	11.3%
Fewer resources available to support audit	(84)	45.2%
Resources for audit have not altered significantly	(81)	43.6%

Once again, remarkably consistent results have been attained in response to Q14 looking at resourcing for clinical audit. For example, despite small fluctuations those stating they have 'more resources to support clinical audit than 12 months previously' have scored between 10% and 17% in all seven annual surveys conducted by CASC between 2010-16. The line-graph overleaf illustrates results from 2010-16 with perhaps the main other noticeable feature being the 'zig-zag' effect each year between responses rated as 'fewer resources' and 'resources not altering significantly'. The concern for those who work in clinical audit will quite simply be that for seven consecutive years less than one in five respondents have reported an increase in resourcing. Indeed, results for 2016 identify only 1 in 9 respondents stating that they have more resources than 12 months previously. Set against the on-going initiative to reinvigorate local clinical audit, this set of data raises concerns.



Questions 15-17 were added to the 2014 survey and have been retained.

Q15. Do you have a twitter account?

30 respondents did not answer Q15. Of the remaining 188:

Yes	(97)	51.6%
No	(91)	48.4%

Results identified a significant increase in the number of respondents reporting that they have a Twitter account, up from 36% in 2014 and 37% in 2015.

Q16. Do you tweet on clinical audit?

Of those 188 respondents who stated they had a twitter account (see Q15), 6 skipped Q16. The results for the remaining 182 were as follows:

Yes	(55)	30.3%
No	(127)	69.8%

Surprisingly, although more respondents stated that they have a Twitter account (see Q15), the proportion stating that they tweet dropped from 39.3% in 2015 to 30.3% in 2016.

Q17. Which of the following clinical audit twitter accounts do you use and how do you rate them?

The following list provides details of the most 'popular' Twitter accounts:

HQIP twitter	62
CASC twitter	56
NQICAN twitter	41

Ratings for clinical audit twitter accounts:

Twitter account	Users	Not at all useful	Not useful	Average	Useful	Very Useful	Score*
CASC	56	1	0	3	24	28	4.39
HQIP	62	0	4	13	34	11	3.83
NQICAN	41	0	4	14	18	5	3.59

Please note: the score for each resource was calculated using the following formula: 5 points for a 'very useful' response, 4 for 'useful', 3 for 'average', 2 for 'not useful' and 1 for 'not useful at all'. Total scores were then divided by the number of replies for each resource to attain an overall rating score.

For the second year running, respondents identified HQIP's twitter as the most used, but CASC's twitter as the highest rated. It was good to see ratings for all three accounts listed above improve significantly in the last 12 months.

Questions 18-19 were added in 2015 given that at the time of that survey (December 2015) the ten-year anniversary of Sir Liam Donaldson's call to 'reinvigorate local and national clinical audit' was approaching. We have retained the question as it remains of significant importance.

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

33 respondents did not answer Q18. Results for the remaining 185:

Yes, reinvigorated	(40)	21.6%
Not sure	(51)	27.6%
No, not reinvigorated	(94)	50.8%

Q19. Ten years ago Sir Liam Donaldson stated 'national clinical audit needs to be reinvigorated'. From a personal perspective do you think this objective has been achieved?

39 respondents did not answer Q19. Results for the remaining 179:

Yes, reinvigorated	(38)	21.2%
Not sure	(63)	35.2%
No, not reinvigorated	(78)	43.6%

Results for questions 18 and 19 are similar to those reported in 2015. However, there has been an increase in those reporting that clinical audit has not been reinvigorated: local audit 41.7% answered 'no' in 2015 compared to 50.8% in 2016 and for national audit 35.9% answered 'no' in 2015 compared to 43.6% in 2016. Those reporting that local and national audit has been reinvigorated dropped by small amounts over the same 12-month time period.

CASC summary

The Clinical Audit Support Centre would like to pay thanks to:

1) All those who took time to complete the online survey
2) All those organisations such as HQIP, NQICAN and regional clinical audit bodies 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 2016). We acknowledge that there are some limitations and the response rate could be higher, although the 218 respondents for 2016 is the highest reported since the survey commenced in 2010. Also, we note that there may be some bias towards Clinical Audit Support Centre (CASC) given that respondents effectively return their survey to CASC. For example, ratings for "usefulness" of clinical audit resources (Q12) and ratings for "usefulness" of clinical audit twitter accounts (Q17) are likely to biased in favour of CASC.

The next step for this report is for the CASC team to make these results available to as many clinical audit and quality improvement professionals as possible. In essence the study represents the views of those working in clinical audit and therefore we consider that this publication belongs to them. In addition, CASC will endeavour to circulate this report to a range of national organisations with a responsibility for clinical audit in the UK. With this in mind the results will be sent to NHS England, Healthcare Quality Improvement Partnership and the National Quality Improvement and Clinical Audit Network. We invite feedback and comments from these organisations and CASC will publish these once they have been received.

On a final note, the CASC Directors try hard not to pass comment on the results and simply provide a factual account of the data. However, we welcome broad discussion on the report and welcome comments via Twitter (@cascleicester) and via other clinical audit and quality improvement networks and forums.

Information on the appendix:

This survey is undertaken in CASC time and CASC receive no funding for carrying out this work. CASC believe that surveys should be conducted in a fully transparent manner and therefore in addition to providing the quantitative data this report also includes all comments provided by respondents. For information, we have not altered any comments and they appear in the format submitted - hence typos, spelling and grammatical errors are included. Comments have been placed in alphabetical order. Where comments have been duplicated they are grouped together. All unique comments appear individually in each appendix.

Appendix 1: Further responses for those who replied 'other' in Q1:

- Admin manager with clinical audit responsibility
- Clinical Audit Coordinator
- Clinical Audit Facilitator
- Clinical Audit Manager now training in Quality Improvement
- Clinical Audit Officer
- Clinical Effectiveness professional
- Consultant
- I work in clinical governance but also I'm a clinical auditor by background
- NHS Manager
- NICE Manager
- Quality governance lead without direct responsibility for audit
- Research and Audit professional
- Specialty Doctor.

Appendix 2: Further responses for those who replied 'other' in Q3:

- Acute and community
- All sectors of HSC
- And community
- Arms Length Body (x2)
- Combined acute and community
- Commissioning (x2)
- Community and Mental Health (x12)
- Extended care
- Health and Social Care
- Hospice (x5)
- I have worked in Mental health, community and acute hospital in last 12 months
- ICO Integrated Care Org Acute>Community/Social
- Integrated Care Organisation (x2)
- Medical Royal College
- Mental Health, Community, LD, Forensics, Primary Care
- National QI
- NHS Blood & Transplant
- Our Trust is an Acute and Community based Trust

- Private healthcare
- SHA
- Standards, Quality and Audit (all sectors)
- Third sector.

Appendix 3: Full responses of those who provided an answer to Q7a 'What do you consider to be the most effective national audit?'

- A means benchmarking practice
- Airway audit NAP5
- All audits are effective in quantifying
- All of them
- Any of the RCEM NCAs
- As interim manager not in a position to say due to different NHS Trusts I have worked in
- Asthma
- At present NELA looks to be worth participating in and our 3 years participation (to date) has results in improvements being implemented for the patient group
- British Thoracic Society ones
- BSR RA&EIA
- Can't compare only involved with a few of them
- College of Emergency Medicine
- COPD (x2)
- COPD. It has highlighted areas in need of improvement and has led to a number of improvements
- Dementia
- Difficult to say which audit is 'effective' because it's not so much the audit results themselves but 'making change happen'. This aspect is down to the lead/s & organisational priorities
- Don't do them
- Don't experience enough to comment
- Don't know
- Don't know - have limited experience
- Early Intervention
- Ensure clinical risks are reduced in certain areas and improve clinical practice so it is better quality
- Few for mental health so can't comment
- Hard to specific as reports are often out-of-date by the time of publication and therefore much work locally has already been implemented before reports become available
- Hospice UK
- I don't think that any of them are particularly effective; I have issues with all of the ones I participate in. POMH are the most approachable / helpful
- I have not had much National Audit experience over the past few years, as a more senior colleague managed these for my previous Trust. Since I moved Trusts, I have become involved in the prostate cancer and emergency laparotomy audits. The NELA audit seems to

me to be the most effective
- I have only worked on two national audits at this time. Of those EIP was more comprehensive although a significant burden on staff to complete
- I predominantly work on POMH-UK audits
- I see v little in the way of audit influencing change in practise
- IBD National Audit (x2)
- ICNARC (x2)
- Inpatient Falls
- Live data collection and quick turn around when publishing national reports
- Local clinical audit, when done well, appears to have the most impact to actual practice
- Many mandatory national audits appear to be more within the category of a registry rather than an audit
- MI not bad but reports poor
- MINAP (x2)
- Myocardial Ischaemia National Audit Project (MINAP)
- NA
- NAS
- NCAA - only because it is the most concise - and does not expand into the realms of collecting multiple data fields which just for 'interest' rather than value
- National Audit of Schizophrenia
- National Audits requirements are simply too vast and this reducing capacity for more local level auditing that clinicians find more useful
- National Diabetes Inpatient Audit (NADIA)
- National Diabetes Survey
- National diabetic foot care audit was the only audit our trust was eligible to participate in
- National Emergency Laparotomy Audit (x2)
- National Hip Fracture Database
- National Sentinel Stroke Audit
- NCEPOD - but I don't see all of them to be able to judge properly
- NCEPOD Studies
- NCISH
- NELA (x9)
- NELA National Laparotomy Audit
- Neonatal Intensive Care
- NHFD
- NIV but this is questionable
- NJR
- NNAP (x2)
- None
- None as they are not Clinical Audits, if you look at the definition of a clinical audit you will that the so-called national clinical audits do not comply to this definition
- None in my Trust we don't take part properly and don't do anything with the results

- None of them
- None relevant to participate in
- Not sure (x2)
- Only involved in NCAA
- Only involvement is the CQUIN National Audit for Cardio Metabolic
- ParkInsons (x2)
- Patient centred specific audit
- PICANet
- Please clarify what is meant by `effective'
- POMH (x7)
- POMH UK audits as these are really useful to us as a Mental Health Trust
- RCEM
- RCEM audits are the only ones I've been involved with
- Rheumatology Audit
- Royal College of Emergency Medicine national audits
- SAMBA
- Sentinel Stroke
- SSI
- SSNAP (x23)
- SSNAP/National Hip Fracture Audit/National Emergency Laparotomy Audit. They are equally effective
- Standard of National audit is improving so much so that by gaining healthcare professional input/ buy-in & trying to make sure results are fully reviewed and disseminated locally most are now becoming more effective
- Stroke (x3)
- The audit relating to the National Mental Health CQUIN for cardiometabolic screening is the one that has generated the most change in our Trust
- The BTS audits
- The national dementia audit in the past has driven change although some of the questions were difficult to interpret. National #NOF database has also developed well over time and has helped drive change
- The one where the loop is closed, the organisation learns and care improves as a result. I can't think of one
- They all seem pointless data collection exercises as I have no idea how or what the specialties do with the recommendations from National Reports
- Those that are valued by clinicians as helping them to identify where they need to improve and give them evidence that they need resources or help with improved organisation
- UK Parkinsons
- Unsure.

Appendix 4: Full responses of those who provided an answer to Q7b 'What do you consider to be the least effective national audit?'

- 7 day service (x2)
- All
- All of them
- All the rest
- All useful to some extent
- Any of the British Association of Dermatologists NCAs (not part of NCAPOP) - they do not supply a report following submission of data
- Any of the registry based audits
- Any that do not have local data and any that have data more than 12 months old included
- Anything more acute medicine
- Bronciectasis
- BSG IBD
- BTS
- BTS audits do not generally have a full report with recommendations
- Care of the dying. I dunno
- Cancer ones alright (the new Head and Neck one seems totally ridiculous and wont work) ridiculous data set like a wish list from years ago
- CEM
- Chronic Neurodisability
- Concern about the data
- COPD or Head and Neck Cancer - massively unwieldy, time consuming and with outputs that don't help with action planning
- CQUIN for physical health in MH
- Diabetes (x2)
- Diabetes not at all good
- Difficult to say
- Don't do them
- Don't have wide enough exposure to national audits to comment
- Don't know
- Don't know - have limited experience
- Early intervention in psychosis (EIP)
- HandN
- Heart Failure
- HMB
- I don't really know
- IBD
- Inflammatory Bowel Disease
- National Audit of Intermediate Care (x8)
- Joint Registry
- MINAP (x4)
- MINAP in our Trust as not emergency intervention centre
- Most of them
- NA (x6)
- NADIA Audit

- NAIC - Did not provide any information the service feel can be used to improve practice
- National Audit of Dementia (x2)
- National audits which compile multiple years worth of data into one report i.e. 2012.2-15 data and offer limited/no organisational data
- National Cardiac Rehabilitation
- National Clinical Audit of Early Inflammatory and Rheumatoid Arthritis
- National Diabetes Audit (x2)
- National Joint Registry
- National Rheumatology Audit
- National/trust audits are often mandatory and therefore unpopular. The methodology is often not appropriate to the department
- NCEPOD (Included in the QA list so included here even thought technically not audit)
- NCISH
- NDFA
- None in my Trust we don't take part properly and don't do anything with the results. It is the same with all of the national audits really. None relevant to participate in
- Not sure (x2)
- Not sure. A few contenders!
- Only one other audit: COPD. Presumably useful for NHS England/commissioners? No use at Trust level.
- Only participate in one
- Outcome and action that arise from all the audits
- PCI
- Please see my last response
- POMH (x2)
- Pulmonary rehab
- RCEM
- Rheumatology
- Safety Thermometer
- See previous
- See previous answer
- See previous response
- See question 7
- See response to question 7
- Seven day service (better this year, shambolic last year)
- Slow issue of national reports
- Smoking Cessation
- SSNAP
- SSNAP - because it is managed the most effectively within the Trust, has the most 'buy in' from Clinicians thus has a successful action plan / implementation/ Improvement etc for impacting on patient care
- SSNAP - does provide service level data however national data combines rehab teams and early discharge teams together. They are very different teams and do not provide appropriate comparison. Because of this the trust are not able to draw any conclusions in relation to national data. Performance is also effected by

commissioning, so results suggest results are poor the service is not commissioned to provide certain services. The reports do not allow for this to be taken into account
- Stroke
- The national intermediate care audit is probably the least effective, we do not participate in it, as the majority of the data collected is n/a giving us no reason to pay to take part
- The where clinicians believe it is poorly designed, collecting too much data/inappropriate data or with poor feedback/reporting
- There are only a few national audits that are applicable to my Trust so not sure my response would be appropriate/useful
- Those that are based on 'the numbers' only without any quality issues addressed
- Those where we have to fill in an organisational questionnaire but don't provide patient level data as it is more difficult to give meaningful feedback
- Too many are pseudo research projects
- Where they is a lot of input, with very little outcomes
- Unsure (2)
- Unsure.

Appendix 5: Further responses for those who replied 'other' in Q9:

- Bespoke system
- By doctors doing their own
- Covalent
- Datix
- Depends on the individual auditors
- Doctors collect their own data as our department is mostly concerned with "bean counting" numbers of audits rather than assisting with the audit.
- Elephant Survey
- Elesurvey (x2)
- For question 11 - both can be effective
- Google forms
- I don't know - we input data to the national audit database directly
- If it is NOT an audit managed by the Audit Department then healthcare professionals have to use Excel or WORD to collect data on
- InfoPath and excel
- InfoPath form on SharePoint
- Internal intranet site surveys
- Laptus
- Largely manual
- Local system
- Meridian (x2)
- Meridian (by Optimum Health) for 95% of them
- Meridian Online System from Optium Health
- Moving to safeguard

- Moving to Smart Survey
- Not sure
- Paper (x4)
- Plus others but not sure of capture
- Our internal computer system - Cerner
- Our own inbuilt Databases and Tools
- Reports generating data from electronic patient records
- SCR for cancer
- Seedata
- SharePoint, simple pen and paper forms
- Smart survey - UK based servers
- SQL analysis of Excel files
- SQL. Access and Excel mix self built monitoring tool
- Statsdirect
- Ts+ Audit System
- Ulysses
- Varies by division and speciality
- Various system
- Word/paper audit tools, Incident reporting (Datix).