SUMMARY OF KEY THEMES

1.0 Theme: HQIP capabilities, profile, governance, strategy and leadership

1.1. Professional group: HQIP Advisory Board, Advisory Group, and, Staff

'Views of HQIP by audit providers vary between lukewarm and frankly awful. There are some people in there working hard, but as a functioning organisation it hasn't really delivered.' – **HQIP Board member**

'I don't think HQIP understands (the difficulty of the front line in hospitals/ Trusts) and I include Robin in this; what it is like to sit around the table at hospital on a Monday morning and deal with the audit findings, the complaints and the clinical incidents.' – **HQIP Board member**

'HQIP also has a struggle to get good people. It has a big focus on contracts, on being micro managers, and there are no clinicians there.' – **HQIP Board member**

'HQIP's role should be managing contracts and national clinical audits; contributing to quality improvement, with measurement pieces. HQIP will lose the opportunity (to refocus) if we just focus on contract management.' – **HQIP Board member**

'The fear of not speaking up is a big issue. It is clear that people know there is a serious problem, but nobody steps back and says there is problem.' – **HQIP Advisory Group member**

'I don't know enough about HQIP [but if I were CEO] I would have ambition, clear communication plans and a clear vision. It is not about being professional and it is not about the Department of Health, it is about the patient, because the public are ultimately paying for it.' – **HQIP Advisory Group member**

'HQIP collates data well but doesn't have any clout. You need an arm into government to enable you to function properly.' – **HQIP Board member**

In response to why HQIP are not leveraged better around key issues given the power of their sponsors:

'Issues of reputation and uncertainty about the future. I haven't been to a Board meeting without hearing about concerns about the tender or problems with securing next year's contract and staff. HQIP is continually going up against uncertainty.' – **HQIP Board member**

'The interesting thing now is that a lot of people in NHS do not know what clinical audit is' - **HQIP Advisory Group member**

'Part of the reason why there is so little political clout is that audit data in itself is not seen as a sexy area, or framed as part of change. Improvement by putting audit at the centre might allow different traction.'- **HQIP Board member**

'If HQIP were working well, it would be a high profile connector, have succinct clear messages and not too many of them, would have the backing of colleges and professional societies, would have the confidence of the Department of Health, would be aligning what they are saying with national directions (for example, regarding stroke), would have ways of showing where someone else has done something already and would have high profile clinicians able to speak to the HQIP quality change agenda.' – **HQIP Board member**

'HQIP is not seen as a player and is not taken seriously.' – **HQIP Board member**

'HQIP could be leading the change. Given all the other noise in NHS, NHS won't and can't do it. When you look at the horizon, who else but HQIP will take (quality improvement) on?' – **HQIP Board member**

1.2 Professional group: CEO, Medical Directors

'I have heard of HQIP and their death by governance.' – **Medical Director, Foundation Trust**

'HQIP's board (must deal with the) issue of politics. People in the House of Parliament who sit on committees get their knighthood not to make real change.' – **Medical Director of Foundation Trust**

'Colleges can be obstacles to change as it is in their interest to maintain the current situation. They get their money from examinations and controlling the work flow.' – **Medical Director of Foundation Trust**

'HQIP needs to think about (audit information) not from a service delivery point of view but from the view of a service receipt.' – **Medical Director Foundation Trust**

'Leaving us alone would be best – I have some sympathy and understanding of why (NHS) have a problem – their solution is to put a safety net under the bottom performance, that is, more of a cargo-net not a safety net, holding everyone down. It is more like sardines in a net, as no one stands out.' – **CE Foundation Trust**

'NHS's actions incentivize bad behaviour. They look for one answer to all of life's problems……' – **CE Foundation Trust**

'[My concern with the] NHS are all these people who don't have an operational or financial responsibility for the front line making up all these stupid bloody rules all the time. It is not their money to burn – it is our money, patients' money, front line money. As doctors we have totally failed to regulate ourselves - they can't have it both ways.' – **Medical Director Foundation Trust**

1.3 Professional group: Clinical Audit Leads

In response to whether HQIP could be led by a medical director in working partnership with the CEO:

'It could be. I have read through HQIP's strategy. It is the initial strategy, where they try to identify their strategic direction for 2008 – 2011…What they need to do is to identify

what the purpose is of doing all that, and what the outcome of the relationship should be. In the national structure, we need to get them to actually focus on making a difference, and then decide how we are going to achieve it.' – **National Clinical Audit Lead**

'[If I were in charge of HQIP], I would try to rebrand or engage in slightly different ways of existing with national audits and try to almost go native. I would try to get 3 or 4 of the most successful national audits together and facilitate them with a concept of what the next big thing of national audits would be. I would try to pick one or two important and productive ways of improving quality. I would change part of the conditions to government as this is where we need to put our funds.' – **National Clinical Audit Lead**

'People need to be more engaged with the audit – we need to provide more assurances about how to data is going to be used.' **– National Clinical Audit Lead**

'Regarding the HQIP brand – it doesn't filter down to level of clinicians – they have the view that things haven't changed since HQIP was formed and are probably unaware that audit is no longer being done by the Department of Health.' – **National Clinical Audit Lead**

'HQIP simply doesn't have profile.' –**National Clinical Audit Lead**

'Partnering is crucial, but HQIP doesn't know how to do this well.' –**National Clinical Audit Lead**

'HQIP needs to appoint a medical director; a respected clinician, in order to generate credibility and clinician engagement.' **–National Clinical Audit Lead**

'I don't really have anything to do with HQIP. HQIP is not really of any relevance to me. I mean I've been running the clinical audit since 2002, and yet I'm not too sure what they do. HQIP has been involved in the logistical setting of us trying to set up NICOR and been involved in mechanics, but actually their impact is quite irrelevant to me.' – **National Clinical Audit Lead**

'HQIP are a huge bureaucracy – big, unwieldy bunch of people. Their role has been to try to get involved in things like intellectual property. They got upset that the data we were collecting all this time was being shared through data-sharing agreements to research people all around the country.'

'There was a lot of hassle as to whether that was allowed, and whether HQIP should approve and rubber-stamp it. I think HQIP were trying to get involved in that side of things which I think has nothing to do with them, aside from them having responsibility to make sure data is used appropriately.' –**National Clinical Audit Lead**

'I don't know what HQIP's goal is – no one knows, but it would be good to find out. It is a marketing/branding issue.' –**National Clinical Audit Lead**

'When people hear about more audits their shoulders slump.' –**National Clinical Audit Lead**

'Clinical audit should be synonymous with QI but HQIP has the wrong people asking the wrong questions and testing the wrong things – Comically unhelpful.' - **National Clinical Audit Lead**

1.4 Professional group: Academic Researchers, Data and Quality Improvement Specialists

In regard to the culture of NHS:

"[NHS] said things like, no information is actually used in improving quality. The attitude in NHS is that of judgement, they look up to managers not out to patients.' – **Professor, University**

"Áudits do add value, particularly at a national level. Great examples include the CEPOD. However, there is a need to have findings translated into actions – few are truly actionable; PDA needs to be part of the process. Also, audits need to be ongoing – currently, many of them start up and then stop.' – **Professor, University**

'There is no one-size-fits-all approach. [HQIP] need to be careful not to destroy something that is valuable, yet on the other hand get the best return on investment. As for local audits, I am in favour of local doctors being in charge, and feeling ownership in a supportive, well-researched way, but there is not enough support to get action.' – **Professor, University**

1.5 Professional group: Partners, consumers and College representatives

'HQIP's great weakness is that they believe the right way to share audit results is in a quiet way through having a conversation in secret with clinicians, "we will just share it with them … they will understand".' **Consumer**

'If I were CEO of HQIP, the first thing I would do is acknowledge that we need help in working out what is our role in this debate, asking the question 'how do we not get killed by the debate?' – be a real trusted broker. I would focus on the outcomes of clinician engagement, an informed debate and wider use of the data. I would do this by sharing the data with organisations. We would get data and we would be trying to get that information into clinician's hands. How HQIP manage that debate is a real issue for them. HQIP constrain themselves – I would rather they came out with a program to push that data and meet with the push for transparency – and I keep pushing them to do so.' – **Consumer**

'The key question is whether HQIP will be part of the change that is happening regarding transparency or whether they will remain underground in the vault.' – **Consumer**

'HQIP has been about data collection, analysis and working hand in glove with the DH, but their role could be more if they pushed the Department of Health further.' – **Consumer**

2.0 Theme: NHS Culture on HQIP Culture and Approach

2.1 Professional group: HQIP Board, Advisor Group, Staff

'We are constantly micromanaged by the Department. They want us to reduce our profile, have demanded that we remove our name from national audit announcements.' - **HQIP Staff**

'Reliant on DH for tendering and governance, limits true independence.' - **HQIP Staff**

'The number and variety of drivers for change (ie Safety thermometer, CQUIN targets, Trust specific dashboards etc) tend to lead to a focus on compliance and meeting minimum standards rather than on improvement – the "must do's" but not the "good to do's" – and most of these are driven by other organisations not HQIP – so HQIP's profile in QI is very low.' - **HQIP Board member**

2.2 Professional group: CEOs, Medical Directors or Trusts

'No real connection currently between clinical audit and QI.' - **Former Trust CEO**

'Audit is largely used as a stick for poor practice rather than a motivator for QI.' - **Former medical director, adviser to NHS Institute**

'There are lots of organisations involved in QI, not joined up, little coordination of effort.' – **Former Trust CEO**

'Way to best engage Trusts, CEO's MD's is to use existing local management structures, close to Trust operations.' - **CEO Foundation Trust**

2.3 Professional group: Clinical Audit Leads

'Most audit is perceived as a pain in the arse because it is retrospective only and intermittent. To be of value, audit must be perceived to be useful rather than bureaucratic, pedantic or slow.' - **National Clinical Audit lead**

'There are too many audits that don't lead to anything so most people lose interest.' – **National Clinical Audit lead**

'Seems to be no integrated thinking between HQIP and DH.' –**Trust audit lead**

2.4 Professional group: Academic Researchers, Data and Quality Improvement Specialists

'HQIP is not independent, captured by the DH and NHS politics and culture.' **Professor, University**

2.5 Professional group: Partners, Patients, and College representatives

'Audit is often not a complete cycle. participation is mandatory, ending once the data are presented , so results are not followed through. So while clinicians are signed up to national audits, they don't like it and it becomes negatively perceived.' – Former Medical Director, adviser to NHS Institute

'Champion clinicians are the most important drivers of QI – if docs champion it then it tends to be adopted – so audit backed by these clinicians is vital.' **– Senior executive, NHS Institute**

3.0 Theme: Clinician engagement and support for improving their practice

3.1 Professional group: HQIP Board, Advisory Group, and, Staff

'For clinicians the patients' stories are the most important thing.' – **HQIP Advisory Group member**

'We have run a project with junior doctors in training – it is one of the requirements for them. They see it as onerous, which makes it a chore.' – **HQIP Advisory Group member**

'Junior doctors can become champions when they leave – that is the vision.' – **HQIP Advisory Group member**

'HQIP seen as audit commissioning and little else – so administrative rather than driving strategic change as a result of audit.' – **HQIP Board member**

3.2 Professional group: CEO'S, Medical Directors

'Too many audits, too often – if fewer, relevant prioritised audits then engagement would be easier and more meaningful.' - **Trust Audit lead**

3.3 Professional group: Clinical Audit Leads

'About five years ago, we set up the national audit database and we ran it online. At the end, clinicians didn't see the visible return for their hard work and effort. So why should we spend their valuable time? We looked at some other specialties, and designed the program again.' – **National Clinical Audit lead**

'Good practice comes when the specialties participate. (We must) engage them in the beginning, (and make sure) the specialties sign up.' – **National Clinical Audit lead**

'I think the clinicians are interested in getting data for improvement. All the people on the ground are desperately keen to improve quality. The general feeling you get is that people want things to be better. I think what they struggle with is the effort at commissioning provider-management level. So my hope is that we can get objective, comparative level data and create levers for change and put the professionals on the ground – get meaningful data that creates change.' – **National Clinical Audit lead**

'Clinicians will not take up audit unless they are seen as mandatory, useful, integrated, and unless clinicians feel they have ownership over them. They must be co-leaders and involved in the process, that lead to learning rather than compliance, that the audit changes patient care through an engagement strategy and that there is a solid methodology.' –**National Clinical Audit lead**

'They need funding, resources, all data connected and linked up, KPI's as part of the performance management system and linked to pay for performance or non-pay for non-performance.' – **National Clinical Audit lead**

'Patient stories are a powerful form and from an individual perspective, keeping learning and treatment is important for improvement. You need to demonstrate where you are to gain support. People look at the headlines - executive summaries are vital, and the details behind that are important for individuals to use to support their services. The comments and feedback we get are diverse regarding the range of data to support change.' – **National Clinical Audit lead**

'This year we have been working on a much greater communications policy. I have been presenting around the country, and will be nationally presenting in a couple of weeks. It has put us on map, and has made people feel as if something has been done there. We are hoping people will utilize it themselves.' – **National Clinical Audit lead**

'I'm not sure (clinicians) want to see themselves benchmarked. We are hoping to change that way of thinking. It will probably take a few years.' – **National Clinical Audit lead**

'The increasing scrutiny around audit and the way it is being used as leading to risk aversion is a very important point – something that has underpinned nearly all my work in this field. Cardiac surgeons, whatever they tell you, are very risk averse now. Privately they admit this but in public they will always deny it. You can entirely understand why they are risk adverse – it's because of how data is being collected and how it is being used. There was a whole course of the FOI request via a Guardian inquiry– where raw unadjusted mortality data was just pushed out into the newspapers. This caused a bit of a meltdown. Many repercussions continue – there are a lot of sick patients in UK who do not get a transplant cardiac operation because of that.' – **National Clinical Audit lead**

'Clinicians see audits as being in the political view – people are jaded, which affects how audits are perceived and supported. Support for change is very poor - data collection is good but there is no interest and no money so people lose interest.' –**National Clinical Audit lead**

'Why is there a gap between HQIP and clinicians? A lot of us see HQIP as another government body which might not be around long, hence raising the question "so why get too involved?" The perception is that we have professional groups such as colleges and we already have this information - so it is just another parallel process. I suggest HQIP engaging with the colleges would be the most productive way to get clinicians on board. HQIP does that poorly.' – **National Clinical Audit lead**

'There is an underlying cynicism preventing people from getting involved in leadership on audit issues. This leads to a lack of openness, as people are trying to survive.' – **National Clinical Audit lead**

'HQIP – is a bureaucracy – not intellectually very sparkling and very little understanding of audit – audit should be clinically led not bureaucratically led – and HQIP cannot make judgements on things they do not understand – leads to further delay in outputs' – **National Clinical Audit lead**

3.4 Professional group: Academic Researchers, Data and Quality Improvement Specialists

'The attitude of the profession on whether audit is used for improvement, this is the issue.' –**Professor, University**

'Devolving responsibility down to clinicians is what you need, whether that happens is hard to see.' –**Professor, University**

'There is no point collecting data if you're not going to do something with it.' – **Academic, University**

In response to whether he thinks there are barriers:

'From the point of view of the practical clinician, there is the danger that so many national audits have developed, that in the end one might lose energy and the ability to put good quality data in.' – **Academic, University**

3.5 Professional group: Partners, Patients, and, Colleges

'One of the things that has shifted with this business in relation to HQIP that is relevant and a common biggest issue has been in clinician engagement.' – **Consumer**

'Clinicians need to own (the clinical data) – which is fine to a degree.' – **Consumer**

What we are trying to do is find ways of making it work for clinicians – and that is what HQIP are completely rubbish at.' – **Consumer**

'You can push out endless amounts of data and you can feel good about that. You can keep doing that forever but it distracts you from the main point of engaging clinicians with the debate around quality.' – **Consumer**

'HQIP fear that if they share data, people will use the information for their own purposes – they see that as a risk. From a clinician's perspective they don't understand when they spend that much of their time on audits and yet nothing comes out of that effort. That situation is the worst possible thing – spending clinician time on audits with little outcomes for them.' – **Consumer**

'If HQIP keeps its data underground, it will ultimately block engagement by clinicians.' – **Consumer**

'HQIP could be more influential if it made audit outputs more accessible, more practical simple to access.' – **Senior executive, NHS Institute**

'HQIP needs to improve communications between parties involved, work quicker, communicate re value.' – **Former Medical Director, adviser to NHS Institute**

4.0 Theme: Stakeholder management; including patient, consumer and effective communication

4.1 Professional group: HQIP Board, Advisory Group, and Staff

'The doctors on the ground are important. It seems odd that Trust CEs are not on the HQIP radar as they are the people who control what happens locally. The trouble with the Foundation Trusts is that everyone is doing their own thing – their question is now what is in it for me? (to do this quality improvement/clinical audit). Managers I have dealt with are okay as they respect what you are doing and why.' – **HQIP Advisory Group member**

'When you look at the relationship with CEs crying out for information to help them because they are sitting in their own pile of whatever and they are trying to make a difference, sometimes with restricted and limited resources, then it would be very useful for HQIP to demonstrate exactly what processes there are to enable or prevent that failure.' – **HQIP Board member**

'If HQIP were to improve, they should not just focus on clinicians, but focus on CEs as well – who need audit information to be usable and accessible.' – **HQIP Board member**

'HQIP has not been proactive with engaging stakeholders – too passive which has made it difficult to build its role in QI.' – **HQIP Board member**

4.2 Professional group: CEOs, Medical Directors of Trusts

'On quality leadership, RCN and other colleges have lost their way. Colleges are medieval guilds, and the Academy is the guild of guilds – the Colleges are really only focused on the self-interest of clinicians.' – **CE Foundation Trust**

'There is an enormous climate of fear among the Trust managers – here we are as a Foundation Trust and there is not so much concern here.' – **Medical Director, Foundation Trust**

4.3 Professional group: National Clinical Audit Leads

'One of the things we have struggled with is engaging with Commissioners and having a sense of who Commissioners are and what they need in terms of quality data. That's probably partly because of the NHS shake up that there's been no natural way for us to engage with the Commissioners around the country, to the extent that I've never had a meaningful dialogue with any Commissioner about epilepsy services. We are just trying to publish our results.' – **National Clinical Audit lead**

'HQIP needs to lock into the professional bodies. If they get them together they will bring the clinicians along.' **–National Clinical Audit lead**

'Need to engage clinicians first and demonstrate the value of participation – even if it is mandatory.' - **National Clinical Audit lead**

4.4 Professional group: Academic Researchers, Data and Quality Improvement Specialists

'You have to try to manage two sets of relationships. One relates to sponsorship and getting funding from Government – the Department is very bad at managing the sponsorship relationship. The other is being adept at ensuring responsibility that gives enough incentive, yet does not become micro-management and stifle your ability to operate. The real challenge is one that no-one knows yet where the Department is heading.' – **Professor, University**

'The most obvious way for change is through the Colleges and major specialty interest groups.' – **Professor, University**

4.5 Professional group: Partners, Patients, and College representatives

'What HQIP needs to understand and recognise is that there are different publics – it is possible to have controlled access to audit information until it is properly analysed.' – **Consumer**

'HQIP needs to raise its profile – build awareness among clinicians' – **Senior executive, NHS Institute**

5.0 Theme: HQIP expertise in applying audit information and promoting quality improvement

5.1 Professional group: HQIP Board, Advisory Group, and Staff

'Here's an interesting point – if you give people a lot of results … they will hone in on the results that affect them. When there is too much data the big messages can be lost.' – **HQIP Board member**

'HQIP recognises health care providers' concern at volume of national audits – this results in overload and healthcare providers reluctance to respond to outputs' – **HQIP Staff**

5.2 Professional group: National Clinical Audit Leads

'There is a lack of clarity – getting it right in the beginning would be much better. If the local clinical audit people trust the audit from the beginning, they will ensure the recruitment is happening.' – **National Clinical Audit lead**

'You need to take people with you. They need to be part of the vision.' - **National Clinical Audit lead**

'The issue is that (the audit) would not work unless it was essentially initiated by clinical specialties. We need specialty in the big hospitals – not just through a clinical director but a quality lead, although I appreciate the tension of budgeting and quality issues.' – **National Clinical Audit lead**

'For some audits some of the steps were mind-numbing.' – **National Clinical Audit lead**

'The key question for academic clinicians in relation to audits is: what's in it for me? They are unsure. For many audits, it is just a lot of routine checking.' – **National Clinical Audit lead**

'Three things are needed to transform the situation HQIP faces around audits. They need to ensure high quality methodological input with a tailored methodologies approach, not one size fits all. This should contain a qualitative element – stories. They should have clinical leadership within HQIP – respected person or no one will want to work with HQIP. Finally, they should reduce the amount of bureaucracy within - the day to day work on contracts is appalling and is the fault of the Department of Health.' –**Dr, National Clinical Audit lead**

'HQIP are a contract manager, but I think they can afford to be more like partners. Initially they were fairly on board in making sure we hit our targets, then more removed. Then they worked closer with us when it came to… they had to retain the distance because they were going out to tell the community, so arms-length was necessary.' – **National Clinical Audit lead**

'National and local data isn't joined in – there is no qualitative data so the 'how' is missing; how they make it happen is key.' –**National Clinical Audit lead**

'We need to get away from the year-to-year funding - unless it changes and becomes part of the process it will fail.' –**National Clinical Audit lead**

'Local audits are losing local support, and as a result, fewer resources are being given to local audits. We should focus on national audits as they are the ones that really matter.' – **National Clinical Audit lead**

5.3 Professional group: CEOs, Medical Directors of Trusts

'The problem with audits is that they are too slow – they report three to four years late related to data we pull out of HES.' – **Medical Director, Foundation Trust**

'It is not a case of how many audits you do in a year – it is a continuous audit that counts.' – **CE Foundation Trust**

'There is interest in what we are going to do tomorrow not (what we did) yesterday. The current audit process is about compliance not learning.' – **CE Foundation Trust**

'It would be helpful (for HQIP to get an advisory board of medical directors), but it needs to work on how it communicates – for instance, a website which has all ideas

which would look at being done really well – use young people to do that, and celebrate with enthusiasm. You need to get colleges to get out of the place; you need to find hospitals and medical schools doing good things.' – **Medical Director, Foundation Trust**

'Little practical value in audit reports – very data heavy, huge reports with no clear messaging around findings and recommendations.' - **Trust Audit lead**

'Audit is unrelated to QI, does not deliver clear motivation or rationale for change among clinicians. Doctors only change practice if there is financial reward or a threat of exposing poor practice.' –**Former Trust and Health Authority CEO**

5.4 Professional group: Academic Researchers, Data and Quality Improvement Specialists

'Margaret Thatcher introduced clinical audit in 1990. It didn't work then and I haven't seen any evidence that it has since.' – **Professor, University**

'At the end we have a coding system and you hope it ends up with the right audit. You are disconnected with the whole audit system, which is why I think its best to put money in a smaller number of high scoring national audits.' – **Academic**

6.0 Theme: Implementation of audit results

6.1 Professional group: HQIP Board, Advisory Group, and Staff

'It is about taking the data and implementing it – we know what we need to do is change. There is a cycle of change, as you can see the care of patients has improved dramatically. This is in part due to the fact that more detail is drawn.' – **HQIP Advisory Group member**

'Maybe HQIP could be putting some of this money into quality improvement, (as opposed to) great huge things. I think they could take six Trusts and fund pilot projects. Potentially, this could work and be really useful.' – **HQIP Advisory Group member**

'Not been well supported by Royal Colleges despite their role in setting up HQIP – this is partly down to lack of engagement by HQIP but also the Colleges have not really played their part.' – **HQIP Board member**

'No proper alignment between clinical effectiveness, quality improvement and clinical audit.' – **HQIP Staff**

'Audit reports tend to be data heavy rather than useful at a practical level for nurses – they need to be more relevant for nurses, with case studies, simpler to understand and practical.' – **HQIP Board member**

'HQIP needs to find ways of building a broader role and of communicate better – both to build awareness and to drive change as a result of audit.' – **HQIP Board member**

6.2 Professional group: CEOs, Medical Directors or Trusts

'In a way measurement has become a clinical thing. The improvement and management things appear as if they shall never meet – they are simply not connected up. There is no systematic methodology of implementation – a successful audit often just means additional nurse specialists and the cost increase just gets passed on to the Trust (which doesn't have funds to support it).' – **former Medical Director of Trust**

6.3 Professional group: Clinical Audit Leads

'We have been thinking about how to incentivise. If you are working on the data of national audits, Trusts will get larger tariff for the procedure.' - **Dr, National Clinical Audit lead**

(In response to the question of what he would do to drive the agenda if he were CEO):

'I think (my main focus) would be the system itself. I would ask, "do we focus on two or three market receivable procedures?" One could be a pilot project.' –**National Clinical Audit lead**

'From the national perspective, they really need to join up thinking between NHS individual Trusts and HQIP. At the moment, you get the conflict between the routine collections on clinical data to the registry system. How can we make it easy for people? There needs to be some hard thinking about the national bases to support and to get top-level political support for the national audit.' – **National Clinical Audit lead**

'We feel like we are whistling in the wind, that we are having almost no impact in being able to generate change.' – **National Clinical Audit lead**

'Without clear and tangible outputs that are put into practice, audit is not worthwhile – hence the negative perceptions about some mandatory audits.' – **National Clinical Audit lead**

'Worst audits are centrally driven as they often do not relate to measurable outputs which can make a difference – they are often set up with no empirically measurable aspects, and outputs are too slow, too much detail, not relevant to practice.' – **Lead National Audit lead**

'QI is driven by clinicians and peer groups working together – but an effective infrastructure for QI would make a big difference. QI is confused by the number and range of different organisations and different agendas in the NHS – but HQIP is good.' - **National Clinical Audit lead**

6.4 Professional group: Academic Researchers, Data and Quality Improvement Specialists

'(NHS is) a force to reckon with, but in the end you can't just build a wall. This gets in the way of doing a lot of things you need to. If that energy could be tilted towards a necessity of integration, a lot could be achieved.' – **Professor, University**

(In regards to whether it is the mechanics or the uptake that is the real challenge in audit):

'There is no problem in doctors knowing what to do. What to do is no problem at all, doing it is the problem.' – **Professor, University**
(In regards to why it is not done):

'This is attributable on two levels: massively centralised health service – the head of NHS talks about Stalinist control of the NHS…This is an unacceptable situation. There is a massive amount of control from the centre; funding, promotions, knighthoods, promotions, all these things are via the centre. Everyone looks up but not out, due to a culture of fear. It is difficult for the medical profession to survive in that situation.' – **Professor, University**

'If the attitudes won't change then the system won't change.' – **Professor, University**

'We also have to make positive comments - NHS is now publishing adjusted hospital death rates. We are the first country in the world where this is happening, only one of twelve countries using our data and beginning to implement methods.' – **Professor, University**

'There is still a culture of blame in the NHS. [I am] concerned that people who make those positions would be willing to toe the line. The potential is there. I am sure they could do it; they are able to in right circumstances.' – **Professor, University**

'Why are we as a medical profession not making the information available? It is a shame we have not. It is totally wrong that we did not.' – **Professor, University**

'It's all about engagement.' – **Professor, University**

6.5 Professional group: Partners, Patients, and College representatives

'Data needs to be coupled with some sort of engagement, social action and behaviour modification. This goes back to Japanese Kaizen ideas.' – **Consumer**

'Audit outputs need to be more explicit, more practical, aimed at helping the people that participated – partly communications, partly content.' - **Former Medical Director, adviser to NHS Institute**

'Clinicians who are not drivers of audit tend to see it as a process to generate data with no real value – the results are not presented in practical meaningful terms so they are of little value to clinical practice. This is partly about content and a lot to do with communications.' – **Senior Executive NHS Institute**

'We should be using continuous review rather than snap shot audits which are not a good basis for decisions' - **Former Medical Director, adviser to NHS Institute**

Distilling the feedback, identifying themes, issues and concepts

The 58 interviews of key figures and feedback from a dozen other leaders included a number of prominent figures regarded as 'elders' within the NHS context as well as those at academic and operational levels – clinicians, clinical audit leads, CEs and Medical Directors in Trusts. We also talked to patients. Their comments gave a holistic view of the issues and context for HQIP and the work of the clinical audit leads and the relationship between HQIP, its partners and stakeholders.

Collectively the responses provide a rich vein of independent internal and external perspectives on HQIP – a snapshot of opinion of its role and future, the drivers and barriers to real change, and the core issue of clinician (and organisational) take-up of clinical audit as part of that process.

Our desk research provided a frame of reference to scope the topline issues, and we used a range of reports and commentary to develop a preliminary discussion guide for the first wave of interviews with the HQIP 'family' – Board members and the executive and members of the Advisory Board.

The willingness and generosity of the 58 to participate, often at short notice, was a positive indicator of the belief held by most that clinical audit is a fundamental step towards real change and QI in health outcomes for patients.

But there is a significant and very clear implementation gap visible to almost all of the respondents. What became clear as the interviews progressed was that HQIP and clinical audit had become disconnected with QI and operational change. Closing this gap is a critical need for HQIP to achieve or risk being seen itself as failing in its stated vision outlined in the brief:

> *Our (HQIP) purpose is not to gather data on how to improve for the sake of it; we are concerned with improving clinical care. Commissioning a good study is not enough; we have to see action happening as a consequence."*

A key quote from one interview succinctly captured this challenge:

> *'In a way measurement has become a clinical thing. The improvement and management things appear as if they shall never meet – they are simply not connected up. There is no systematic methodology of implementation – a successful audit often just means additional nurse specialists and the cost increase just gets passed on to the Trust (which doesn't have funds to support it).' –* ***former Medical Director***

The interview material was collated and progressively analysed and distilled in a series of workshops in London and in Sydney. Common themes, issues, language and concepts were identified and captured through narrative analysis. Early feedback enriched the later interviews, leading to deeper understanding around the core issues. Finally, the final recommendations and executive summary were shared with many of the interviewees and others, to ensure the report accurately captured the main enablers that can propel HQIP forward in improving NHS delivered care.

As the feedback occurred, our progressive analysis focussed on identifying within the responses width (numbers of references) depth (level of concern) and vector (role/ position/ context of respondent) to identify common themes and issues. Some that emerged were matters within the ability of HQIP itself to resolve – lack of clarity about its strategic direction, the role of key sponsors some of whom are also competitors, an unrelenting focus on contract management rather than outcomes, HQIP's low profile, a disinclination or inability to partner with relevant groups and individuals, process turgidity, and perceived issues of governance at the Board level. Crucially HQIP is seen by a number of the clinical audit leads to be failing to support them sufficiently in their work. These matters can and must be addressed if HQIP is to progress from its current position.

Beyond Audit-The impact on trainees

An important issue that we heard from interviewees were the mostly unsatisfactory experience that trainees experience with the present audit requirements**.** Trainees have historically been required to undertake clinical audit. These are usually presented as part of a portfolio of evidence at RITA or ARCP panel meetings. However from a survey involving over 880 London trainees (Stanton, 2009) many trainees were very unhappy as noted in this quote from their report:

> *"Audit can be a frustrating process. It often feels like a tick box exercise where a 'for the sake of it' audit is given to the trainee which takes a lot of time and effort for little result…*
>
> *It would be helpful if doctors spent more time in the design and implementation of audit findings rather than the time consuming and tedious task of data collection. "*

Stanton further reported that:

- there are no easily identifiable quality criteria available to guide trainees
- completed audit cycles are rarely performed
- there is little continuation of projects once a trainee leaves the organisation
- the emphasis of 'audit' tends to be on data collection rather than the management of change
- data is often readily available, what is harder is the implementation of change and many important improvement projects may not require data collection at all
- audit is most often conducted as a solitary activity prescribed for the trainee by their supervising consultant
- many trainees view audit as a 'tedious' and irrelevant with their main motivation for participation being that it might help with career progression
- there may be a misconception about what is required by specialty schools for instance for presentation at RCP panels

HQIP could work more closely with the other Royal Colleges and Academy to identify more creative and meaningful ways to make audit requirements by trainees an

educating and fulfilling experience. There is a need identified in 'A High Quality Workforce' (Darzi, 2008) to develop clinical leadership and embed the national Medical Leadership Competencies Framework (Academy of Medical Royal Colleges, 2007) - which places considerable emphasis on service improvement - in specialty training. Trainee audit is a compelling resource for the NHS quality agenda just waiting to be mobilised. Recent pilot efforts by Deaneries in Southwest and London have offered a model for more effective integration of trainees in learning to use and apply audit data for improvement.

Department of Health and HQIP

Factors external to HQIP dominated many discussions. One of the most intensely held set of concerns was about the impact of the DH/ NHS culture of fear, and policies that were seen to work against a genuine transformative role for HQIP in achieving QI in clinical outcomes. Two key quotes that highlight this perspective were:

'HQIP is not independent, captured by the DH and NHS politics and culture of fear.' ***Professor, University***

'Áudit is often not a complete cycle, participation is mandatory, ending once the data are presented, so results are not followed through. So while clinicians are signed up to national audits, they don't like it and it becomes negatively perceived.' – ***Dr, Former Medical Director, adviser to NHS Institute***

While macro issues remain beyond the ability of HQIP to influence, HQIP was seen to be failing to engage sufficiently high levels of government and DH to secure better maneuvering space for itself and for clinical audit.

As we outline in the report above, six clear themes emerged, were captured and further tested in later interviews and sent back to select key stakeholders for their reflections and approval. One of those key concerns was around the lack of an effective communications and engagement strategy and program to build its own profile but also

support the clinical leads in their work. Below is a proposed strategy to address this clear opportunity.

"New Way" - HQIP Communications and Engagement Strategy

I. Overview

This section provides a recommended approach to communications and engagement to support HQIP and its "New Way" during the next twelve months and beyond. A key part of this plan is to change perceptions among key stakeholders as to the role and merits of both HQIP and clinical audit in the delivery of quality improvement and patient and community wellness.

Fundamentally, this perceptual shift is only sustainable if the reality matches what we are trying to communicate, so the changes on the ground must precede the communications initiatives. That said, it is clear how communications must evolve. We set out here the key objectives, target audiences and strategic approach, recognising that some of the tactical planning needs to be undertaken subsequently, since it must reflect HQIP's strategic plan for 2013, how the 'New Way" will be implemented, input from HQIP's communications team and with reference to participation by partner organisations, budget constraints and available resources.

II. Rationale and Objectives

A level of misunderstanding and/or negative criticism of HQIP has been voiced in the course of the project that is at odds with how HQIP is seeking to work and be perceived. These views also relate to clinical audit itself, how it is managed and the value or lack of value that it delivers in terms of QI and clinical value.

A long-term communications strategy is needed to provide a framework both for managing the current position, and to drive longer-term perceptual changes across all these dimensions and to prepare HQIP for future issues as they arise. In the short term, a better-planned approach to communications will help to address the issues and to convey the benefits that HQIP's revitalised approach will deliver. A professional,

consistent communications approach needs to be developed and committed to by the HQIP Board and executive, in partnership with the organisations it works closest with.

The objectives underpinning all communications can be divided between HQIP and clinical audit:

HQIP

- Evidence of HQIP's role in driving QI through better use of clinical audit
- Move perceptions of HQIP away from its reputation as a bureaucratic arm of DH that is purely involved in the administration of the audit process
- Demonstrate that HQIP understands the clinical implications of its work, with genuine insight into the priorities for both clinicians and patients
- Build HQIP's position as a key influencer and thought leader in both the planning of clinical audit, QI and whole system reform
- Raise awareness of HQIP among all stakeholder groups, as an effective and well run organisation

Clinical Audit

- Improve perceptions of clinical audit, how it is managed, how results are used and its long term value
- Enhance the communication and impact of audit results to aid QI

III. Key Stakeholders

There is a complex range of inter-related and interdependent stakeholders who need to be considered in HQIP's communications and engagement programme. These are set out in the earlier section on the stakeholder landscape but in summary the following groups are of priority. Each of these will have a different agenda, so messaging and tactics will need to be tailored appropriately - one size does not fit all:

- NHS Trusts
    - Board
    - Clinicians
    - Clinical governance and audit teams

- QI related organisations, including
    - National Quality Board
    - New improvement body
    - NICE
    - Specialist clinical groups
    - Kings Fund
    - Health Foundation
    - Academic Science Networks
    - Dr Foster
- Royal Colleges
- Department of Health/Commissioners
    - National Commissioning Board
    - Clinical Commissioning Groups
- Patient advocacy groups
- NAGCE
- Media (Conduit to the above)

IV. Strategy

HQIP already runs an active programme of communication, particularly associated with the web site and the issue of media information relating to clinical audit and associated issues. The New Way presents an opportunity to build a more strategic approach to communication and engagement and to tactically, review the content and volume of day-to-day communications. This should be the focus of the development of a new tactical plan now that HQIP's future is certain following the successful tender bid. However, it is appropriate at this stage to set out an outline strategic approach for communications and engagement, including reference to some of the new initiatives that might be considered when the tactical plan is developed.

Key elements of the strategy are as follows:

- Collaborate with key stakeholder organisations in communications activity
- Raise awareness of both HQIP and the role of audit

- Focus communication around stakeholder needs and expectations rather than merely broadcasting HQIP content
- Aim to become the hub of the evolving NHS stakeholder landscape for QI through direct engagement, events and communication. Many of the organisations are new, so HQIP is in a good position to lead on this
- Build role for patient representatives in QI by engaging with them directly, involving them in all HQIP deliberations, and involving them in media work
- Build relationships with individual Trust boards, CEOs
- Build the reputation and credibility of HQIP and its leadership team as thought leaders in QI, with a particular focus on the value of evidence
- Implement more strategic/proactive media relations in parallel with a review of the content and volume routine announcements
- Commit to building and implementing a long term strategic communications plan now that the tender has been awarded

The implementation of this strategy will span three discrete areas of activity:

1. **Collaboration** – actively build a partnership approach to communications relating to QI and audit, so that key stakeholders contribute to and participate in the programme. This is as much about reflecting the company that HQIP keeps as it is about adding weight to the delivery of communications.

2. **Engagement** – actively engage and be seen to engage stakeholders in QI. This is about winning over the 'hearts and minds' to mold the perceptions of these stakeholders so that HQIP benefits from, consultation with and communication through, key stakeholders who understand and increasingly support its role in QI.

3. **Communication** – provide a planned, consistent but not over-excessive flow of information about HQIP, clinical audit and its role in QI and key issues. This will help to build HQIP's position as a thought leader and a collaborative participant in QI within the NHS, as well as being seen as an effective, professional and well run organisation

Many initiatives will embrace all three of these areas, as exemplified by the suggested high level meeting described in more detail below.

Without pre-judging the development of a detailed tactical communications plan, it is recommended that it should include the following areas in relation to high level communication that will support the New Way.

- **Stakeholder analysis** – on-going review of perceptions, priorities, communications channels
- **Communications Steering Group** – involving HQIP leadership to plan, drive and monitor communications and engagement activity, potentially working with key partners (e.g., RCP, Academy, RCN, etc)
- **Messaging** – development of high level messaging, with agreed mechanisms for on-going review and updating
- **Background materials** – online, multimedia and printed. HQIP already produces a wide range of materials for distribution and via its web site. It is not suggested that all of these should be reviewed, but that consideration be given to developing new background materials which provide insight and support for the use of clinical audit as a practical driver for QI
- **Written communications** – review of specification, target audience, frequency (key element), design, production or online etc. In addition to existing communications regarding audit processes, training and outputs, new materials could focus on higher level aspects of HQIP's work in relation to QI, patient safety, potentially in the form of a specialist journal produced in partnership with other QI organisations or perhaps with the BMJ Speciality Journal group
- **Online communication** – creative use of online and social media where there is a demonstrable benefit, either for discrete audiences related to specific audits, or more broadly. The web site is already comprehensive and even content-heavy, so any review should seek to enhance signposting of information as much as changing the focus of the content. Other areas for consideration are the use of online forums, networks and discussion groups relating to specific audit

implementation, issues management and topics of specialist interest. As the owner/driver of these initiatives, HQIP will not only be adding value to its service but will also grow its profile as a key player in QI.

- **Multimedia**—HQIP should consider collecting patient and clinician stories using videotaping, and using these stories in training, engagement, marketing and enhancing the present web outreach
- **Stakeholder engagement** – planning, implementation and reporting for direct interaction with key stakeholder groups. If HQIP is to become a hub for communications relating to clinical audit and QI, then it must become more proactive in building meaningful relationships at all levels with key stakeholder groups. This is as much about developing entrusting individual relationships as it is about group interaction and facilitation of networks operating within clinical audit. HQIP clearly already does this well in relation to national audits and among audit managers within Trusts. In contrast, when it comes to QI, this level of proactivity is as yet either in in its infancy or is not recognised by stakeholders.
- **Events** – review of existing events portfolio with consideration of a new or refined approach that better reflects the strategy. The HQIP conference and other workshop type events already deliver at one level but there is a need to elevate HQIP's role at a more strategic level in QI. Recommendations for a new high level seminar entitled **"Building a new vision for Quality Improvement in the NHS"** have already been submitted, as summarised below*.
- **Media relations** – proactive media relations by HQIP should go beyond publicising the delivery and outputs of clinical audit. This should involve collaboration with partner organisations such as the Royal Colleges, focused at a higher level and on issues and drivers of QI in the NHS. Alternative approaches should be adopted for different media sectors including
    - National and broadcast medical writers
    - Journals focusing on individual clinical specialties
    - Health service management and general medical publications
- **On-going programme governance** – assigning roles, process, budget, resources, mechanisms for reporting and review

- **Timeline** – links to milestones, regular activity, interdependencies, lead times

Building a new vision for Quality Improvement in the NHS

The notes below summarise the recommended high level seminar on "Building a new vision for Quality Improvement in the NHS". This event, to be hosted jointly with the RCP/ Academy of Royal Medical Colleges, aims to stimulate new thinking among senior clinicians, managers and policy influencers in relation to Quality Improvement in the NHS, as follows:

- Establish a top level forum to create a new approach to quality improvement in clinical practice, based on a more collaborative approach between organisations, professionals and disciplines
- Initiate enhanced dialogue between individuals and organisations involved in measuring and changing clinical practice
- Shift the emphasis of quality improvement towards patient care and away from measurement, targets and efficiency
- Underpin HQIP's role in facilitating interaction between organisations and driving change that results from clinical audit
- Build awareness of the event through media and other channels (including online) to help stimulate further interest and participation longer term.

This is a good example of a major initiative which combines the three key components of collaboration, engagement and communication referred to above. All such initiatives should, where appropriate, be developed with this multi-faceted approach inherent in their planning.

The paragraphs above make recommendations for a more proactive and intense approach to communications and engagement. However, we have deliberately not been over-proscriptive as the details of this programme must be built in collaboration with

the Board, executive, and the internal communications team who will play the key role in its delivery.

Appendices

- Appendix 1 Desk research sources
- Appendix 2 Reference to list of people in appendix – names, titles, Organisations
- Appendix 3 Questionnaire

Appendix 1 Desk Research Sources

1. Innovation Health and Wealth - Department of Health
2. Academic Health Science Networks – Department of Health
3. Quality in the new health system - Maintaining and improving quality from April 2013 - A draft report from the National Quality Board
4. Healthy lives, healthy people: our strategy for public health in England – Department of Health
5. Quality Accounts guidance – Department of Health
6. The role of academic health science systems in the transformation of medicine – Victor Dzau et al
7. Quality Report 2012 – West Middlesex University Hospital NHS Trust
8. Misses doses - Quality improvement programme, focusing on error reduction: a single center naturalistic study – University Hospital Birmingham NHS Foundation Trust
9. National Advisory Group for Clinical Audit & Enquiries - Consultation on Future of Audit staff in Trusts
10. HQIP - Guide to Involving Junior Doctors in Clinical Audit
11. HQIP - Guide for Clinical Audit Leads
12. HQIP - Clinical audit: A simple guide for NHS Boards & partners
13. HQIP Busienss Plan 2012/2013
14. HQIP - Strategic plan: Re-invigorating Clinical Audit – 2008-2011
15. Navigating Change: How Outreach Facilitators Can Help Clinicians Improve Patient Outcomes - Dianne Laferriere, RN, BScN, Clare Liddy, MDMSc, CCFP, Kate Nash, MSc, and William Hogg, MClSc MDCM, CCFP
16. HQIP – Advisory Group terms of reference, minutes of first meeting
17. The five practices of exemplary leadership – Posner and Kouzes
18. Leading Change – John Kotter
19. Implementation Science theory & programmes - Martin Eccles, Professor of Clinical Effectiveness, Newcastle University

20. Is the NHS Leadership Qualities Framework Missing the Wood for the Trees? Richard Bolden, Martin Wood, Jonathan Gosling
21. A hospital-site controlled intervention using audit and feedback to implement guidelines concerning inappropriate treatment of catheter associated asymptomatic bacteriuria – Trautner et al
22. The feasibility of automating audit and feedback for ART guideline adherence in Malawi – Lewis et al
23. Using quality indicators in anaesthesia: feeding back data to improve care – Benn, Arnold et al
24. Improving quality of care through improved audit and feedback - Sylvia J Hysong et al
25. A quality improvement programme to increase compliance with an anti- infective prescribing policy - Kandarp Thakkar et al
26. Peer review audit of occupational health reports—process and outcomes - D. Lalloo, I. Ghafur and E. B. Macdonald
27. New Principles of Best Practice in Clinical Audit – edited Robin Burgess
28. Healthcare Quality Improvement Partnership Advisory Group Minutes, 11th October 2012,
29. Leading Through Transformation: Top Healthcare CEOs' Perspectives on the Future of Healthcare - Insights from the Huron Healthcare CEO FORUM
30. Emma Stanton Beyond Audit, Presentation to London Deanary, November 2009.

31. Key online sources
    - Department of Health web site
    - Kings Fund web site
    - Care Quality Commission web site
    - Institute for Healthcare Improvement web site
    - NHS Institute web site
    - HQIP web site
    - NHS Trust web sites
    - Dr Foster web site

- Health Foundation web site
- Academy of Medical Royal Colleges web site
- Royal College web sites

Appendix 2 List of interviewees and informants

Organisation/area	Name	Role
1. HQIP		
Board member	Dr Kevin Stewart	Director Clinical Effectiveness, Royal College of Physicians
Board member, Chair	Janet Davies	Executive director, Royal College of Nursing
Board member	Tina Donnelly	Director, Royal College of Nursing
Board member	Alastair Henderson	Chief Executive, Academy of Royal Medical Colleges
RCP, HQIP advisory board	Dr Linda Patterson	Clinical Vice President and Director of Clinical Standards, RCP
HQIP Staff	Robin Burgess	CEO, HQIP
HQIP Staff	Kate Godfrey	Head of Audit, HQIP
HQIP Advisory Board	Dr David Somekh	European Society for Quality in Healthcare (ESQH), past president
HQIP Advisor Board	Dr Linda J Patterson	Clinical Vice President Royal College of Physicians
2. National Clinical Audit Leads		
MINAP	Dr Clive Weston	Consultant Cardiologist & Reader in Clinical Medicine. Institution: College of Medicine, Swansea University
Angioplasty	Dr Peter Ludman	Consultant Cardiologist, University Hospital Birmingham
OGC	Mr Richard Hardwick	Upper gastrointestinal surgeon at Addenbrooke's
Adult Diabetes	Dr Bob Young	Consultant Physician Salford Royal Foundation NHS Trust
Epilepsy 12	Dr Colin Dunkley	Consultant Paediatrician Sherwood Forest Hospitals NHS Foundation Trust

Paediatric Diabetes	Dr Justin Warner	Consultant in Paediatric. Endocrinology and Diabetes and Secretary BSPED, University Hospital of Wales, Cardiff
Carotid Interventions	Mr Tim Lees	NAAASP Research Lead, The Northern Vascular Centre, Freeman Hospital, Newcastle
Falls	Dr Jonathan Treml	Consultant Geriatrician, UHB
Schizophrenia	Prof Stephen Cooper	Royal College of Psychiatrists
Pain	Dr Stephen Ward	Royal Sussex County Hospital
Hip Fracture	Dr Colin Currie	Lead Clinician (Geriatric Medicine) for the National Hip Fracture Database (NHFD).
PICANet	Professor Elizabeth Draper	Professor of Perinatal and Paediatric Epidemiology University of Leicester
PICANet	Prof Roger Parslow	Senior Lecturer Epidemiology, University of Leeds
Food and Nutrition	Prof Peter Emery	Professor of Nutrition and Metabolism Kings College London
Food and Nutrition	Prof Peter Griffiths	Chair of Health Services Research at Southampton University
IBD	Dr Ian Arnott	Consultant gastroenterologist, Western General Hospital, Edinburgh
Heavy Menstrual Bleeding	Prof Allan Templeton	Past President of the Royal College of Obstetricians and Gynaecologists
3. Chief Executives and Medical Directors		
University Hospital Birmingham	Dame Julie Moore	CE
University Hospital Birmingham	Dr David Rosser	Medical director
Great Ormond Street Hospital	Prof Martin Elliot	Medical director

Kings Healthcare Partners	Prof John Moxham TC	Medical Director, Professor of respiratory medicine
NHS Quest, ex CEO Luton and Dunstable	Stephen Ramsden OBE	Patient Safety Consultant, Former CEO Luton and Dunstable NHS trust
NHS leadership adviser, ex SHA CEO	John de Braux	Consultant, former CEO Beds and Herts SHA
NHS Institute past head	Prof Bernard Crump	Former CE, Professor
4. Others		
National Joint Registry, British Orthopaedic Association	Prof. Joe Dias	President
British Association of Urological Surgeons (BAUS)	Dr Adrian Joyce	President
British Transplant Society	Chris Watson	President
Imperial College	Sir Brian Jarman	Emeritus professor
RCP, BEACON UK	Dr Emma Stanton	CEO
RCP	Jane Ingham	Director of Clinical Standards
WMUH NHS Trust	Paula Guerra	Clinical Audit lead
NHS Institute for Innovation and Improvement	Dr Lynne Maher	Director for Innovation
GMC	Una Lane	Director for Continued Practice and Revalidation
Good Governance	Andrew Corbett-Nolan TC	CEO
NHS Institute	Dr Janet Baldwin TC	Advisor, former medical director, West Middlesex NHS Trust
King's Fund	Dr Nigel Edwards	Senior Fellow
KPMG	Prof Hilary Thomas	Partner, Healthcare practice

King's Fund	Prof Nick Barber	Director of Research
University of Birmingham	Prof Richard Lilford	Professor of Clinical Epidemiology
St Mary's Hospital	Dr Julian Jarman	Consultant, Cardiology
Imperial College, Dr Foster	Paul Aylin	Asst dir Dr Foster, Reader in Public heath, Imperial College
Dr Foster	Roger Taylor	Director of Research
Evelina Children's Hospital	Prof Shak Qureshi	Head of Paediatric Cardiology, Evelina Hospital
Kings College	Prof Jane Sandall	Professor of Women's Health
Kings College London	Prof Graham Thornicroft	Head of the multi-disciplinary Health Service and Population Research Department at the Institute of Psychiatry
King's College	Dr Adrian Hopper	Director of Patient Safety
Royal College of Surgeons	Dr Oliver Groene	Lecturer, London School of Economics and Tropical Medicine (LSETM)
Peterborough and Stamford NHS foundation Trust	Dr Yota Lioliou	Consultant, Surgeon
St Thomas Hospital	Dr Peter Jaye	Consultant, A & E
Great Ormond Street Hospital for Children, NHS Trust	Dr Peter Lachman	Associate Medical Director and Consultant in Service Redesign and Transformation
Cure the NHS	Julie Bailey	
Edinburgh Royal Infirmary, Scotland	Dr Simon MacKenzie	IHI Fellow
University of Leicester	Prof Mary Dixon Woods	Professor of Medical Sociology

Appendix 3 Questionnaire Tool

The key areas we would like you to talk to us about are as follows:

1. Clinical audit
    - How is clinical audit perceived by clinicians?
    - Who instigates and drives clinical audit - National and Local
    - How does clinical audit fit within quality improvement?
    - Does clinical audit deliver clear findings – or are they data focused, unclear re practical changes, indecisive?

2. Mechanics for quality improvement / changing clinical practice
    - How is change in clinical practice driven and manifested? Who makes it happen?
    - How is the need to change perceived by doctors and what makes them act?
    - How would you unblock it?

3. HQIP role in quality improvement
    - How could HQIP enhance the engagement in and perceived value of clinical audit?
    - What role should HQIP play in quality improvement, beyond running clinical audit?
    - What does HQIP need to do differently to improve its reputation among key stakeholders?
    - What relationships does HQIP need to cultivate?