



Stakeholder Survey 2010

How stakeholders see HQIP and how HQIP is responding

October 2010

In May-June 2010 HQIP sought feedback from our consumers and stakeholders about our work. This took the form of an online questionnaire, filled in by 422 people, mostly working at the front line of clinical audit in local trusts, but covering all areas of our business; and detailed interviews with 17 stakeholders.

The majority of people surveyed believe that HQIP is making a significant contribution to the re-invigoration of audit as a whole and within all the various dimensions of our work. Certain areas are regarded most highly:

- The profile we have given to clinical audit
- Our support to local audit departments
- The resources we produce
- Our contract management of national audits
- The knowledge and value of our staff
- Our events

To give a small number of examples:

- 316 / 367 (86.1%) people felt HQIP had helped them to improve their own practice.
- 290 / 368 (78.8%) have used HQIP products and guidance to help others improve their practice
- 77% rated HQIP's achievements in re-invigorating audit as a whole at 7/10 or above.
- In procurement of national audits, 56% rated our work at 7/10 or above.
- 85% rated our Criteria document as 7/10 or above – a “gold standard”.
- HQIP was a national audit's “best funder to date”

The reviews covered everything we do, from relationships with commercial suppliers, through local audit support, our financial dealings, and how we support national audit and carry out development work. The review involved seventeen structured interviews conducted independently between Bryony Soper, Associate Reader with the Health Economics Research Group, Brunel University, and selected stakeholders from various areas of our work; and an electronic questionnaire, sent out to 2660 members of our mailing list, selected at random and then with booster samples added to reflect specific interest groups (clinicians, people working on national audit). 16% - still a large number of individuals - provided responses.

There was no attempt to select people who we knew would only speak favourably about us; but to get accurate, honest and helpful feedback from all people whom we attempt to serve. We did select people for the interview group who knew us in several contexts – national and local, for example, so could speak from a wider, more rounded perspective.

The overall purpose was to assess just how much we were achieving our goal to re-invigorate clinical audit, based on the views of people we seek to work with and influence. This process is not an independent piece of research into whether the profile of clinical audit has improved, nor the quality of audits being conducted can be said to have objectively improved: this was a qualitative process to determine views on the impact of *our* work, from the people whose work we hope to improve over time.

The responses to the electronic survey enable numerical presentation on graphs. This was a large survey with a very detailed set of questions covering all areas of our work, and the tabulated responses are attached below as annex A.

The main observations from the structured interviews have been summarised as annex B.

What did the surveys show?

The two exercises should be read together. HQIP regards the views of the 17 stakeholders with whom detailed discussions as no more important or representative than the 422 survey responses; but they do provide more detail. We value the responses of all our stakeholders, and in this document, try to be honest about what we are doing in the light of what was said.

As a whole, HQIP is pleased with the findings, and the constructive points of improvement suggested. Our stakeholders and consumers generally value what we do and regard it as positive and useful, and they recognise that in a short while HQIP has achieved the primary focus of making awareness of clinical audit much greater. The majority of stakeholders clearly feel that the profile and professionalism of clinical audit is being improved by what we do and we are highly visible. Our staff are regarded as knowledgeable, supportive and effective.

To draw from the qualitative structured interview comments:

From NICE:

“ Q: Would you say that in the time the partnership between you and HQIP has been in place that this system has improved on what was there before? ”

A: Definitely, absolutely.

Q: Could you quantify that – i.e. twice as better, three times as better?

A: It’s probably twice as good.”

“Although there are other parts of NICE that were having discussions about how to engage with GPs and what we could do - not specifically around audit but around the implementation of NICE guidance in general. That was going quite slowly until I then linked it up with HQIP, who were beginning to do a similar kind of thing around the clinical audit work. Once NICE and HQIP started doing it together it sped things up a huge amount.”

By what factor? A: Probably by about times four.”

“HQIP’s involvement has been enormously useful to help the NICE team see what that this work on quality standards will mean in the real world. “

NICE staff members

In supporting Local Audit:

“HQIP organised two conferences that have been fantastic in terms of generating more enthusiasm among clinical audit staff and providing them with access to materials. Some of the materials that HQIP has produced have been really helpful.”

“I think that they have achieved an incredible amount since they took over. I remember saying when they first started that what they were trying to achieve was not possible. But they have. I have really been impressed – as national organisations go they are a good one. I would very much hope that they continue to get funding. “

Local Audit lead and former Royal College QI lead

“The latest paper from HQIP, which was addressed directly to trust boards, is something which we have found immensely helpful in gaining the understanding and engagement of the trust board in a way that has not previously proved possible”

Senior Clinical Lead for audit in a Trust

“Q: Given you attended the first big meeting run by HQIP, can you comment on how well they run such meetings?”

A: It was very good. HQIP are a group we can go to when it comes to these kinds of issues and concerns. They can advise and, even though they are relatively new themselves, they seem to have moulded everything together.”

Regional Network chair

On the NJR:

“Yes, the people who work for HQIP are good....the move to bring HQIP in has been a very positive one in relation to the NJR. It feels more businesslike, it feels more in control.”

NJR steering group member and NHS Trust CE

In Supporting development of audit amongst clinicians:

‘I’m sure that we would be in a very different position now compared with last year if HQIP weren’t here. I’m very grateful for the support that they have given. It would be very helpful to general practice if their contract was renewed.”

Royal College Lead

In commissioning and managing national audit:

“They have seemed able to come to decisions in a business-like way” National audit lead clinician

“Q: Can you sum up what you think HQIP has added?”

A: It has added championing of audit; in the contractual area it has been more organised and more rigorous; and it has added a variety of practical documents and articles that are proving to be really useful at the coal face.”

National audit lead

“We’ve been managed by various people and along the way we have had some poor management. But this is really good. We know exactly where we are, we have regular meetings with them, we go through all our deliverables, and they scope things at a sensible level, where everybody is happy at the end. We always end up with a good conclusion and everybody knows exactly where they stand.

HQIP’s way of viewing and developing audit is having a very positive outcome in that everybody is beginning to recognise best practice in a better way. HQIP are providing the processes for people to learn about improving what’s done, what’s carried out, what data is collected, and how it’s done, and how you feedback, etc. The way HQIP have got themselves organised is facilitating a process of general improvement in audit across the board.

The people I work with at HQIP are absolutely fantastic, there’s no question about it. Compared with the very difficult time we had when we were linked with DH, it has been a sea-change in attitude. It’s very much a can-do, will-do as quickly as possible attitude”

National Audit Lead

Although the majority of comments were very favourable, there were criticisms of our work, notably from two people within the seventeen interviewees in relation to national audit procurement work. They highlight some weaknesses in our procurement process during 2009 and how this might have been improved.

As other correspondents acknowledge, the procurement process has greatly improved this year. We accept that work needed to happen to improve the process, partly through discussion with the Department of Health, but also through internal development. We have recruited new staff and used experienced consultants to complete and improve work on specifications in 2010 prior to recruitment of staff to carry out this function.

It is important to balance the small number of negative comments with the really positive things said by others about this area of our work. Others describe us as the best funders they have ever had, with real interest in what they do:

“Since HQIP took over my perception is that it has been a much more professionally organised unit that has been fairly focussed on the job at hand rather than trying to do this thing of national audit as an irritating by-product of all the things that the organisation as a whole is doing. The previous organisations did the job, but audit clearly was not their primary interest, whereas working with HQIP – it clearly is their primary interest. Their approach is therefore quite distinct in that respect”

National Audit Lead

Furthermore, it was noted that HQIP does not have full responsibility for all elements of the process. Decisions are also taken by the Department of Health and they take advice from the NCAAG group.

Taken as a whole, including events and contract management, the work of the national team is regarded positively.

Overall impact:

“Q: So if you were going to rate the value of HQIP in this respect – let’s say arbitrarily on a scale of one to five where five is good, where would you put it?”

“A: If five is the highest and looking at it subjectively (my interests being in clinical audit for the moment and I have quite a long history in audit) I would say, compared to what has gone before, ‘five’. But then again if I was looking at it from a different perspective and putting it into context and looking at everything else the NHS has to do (and that’s a massive agenda) I might not be so ambitious as to say ‘five’ and might say ‘four’. So being realistic, overall ‘four’.” Local Clinical Audit Lead

Many respondents were careful to say that HQIP operates within a context; we act on behalf of the Department of Health, and our role is not one of policy, but of implementation. Some perhaps felt that we did not offer as much ‘vision’ as they might like, but this reflects the term of our contract with the Department – we are not a body which makes strategy, simply designs a strategy for *implementation* within a vision created by the Department and professional groups. *We are technicians and enablers within a system.* This means that most comments have rightly focused on our role as implementers, facilitators, communicators, and process managers. We have been re-assured that we are helpful, energetic, focused and understanding, and have worked tirelessly to promote audit in an intelligent way. Many correspondents were keen to stress that other factors – and organisations – alongside HQIP, affect the degree to which re-invigoration of clinical audit can be achieved and how much this can be attributed to HQIP itself.

In summary therefore, we believe the two surveys provide an accurate picture of our achievements, our role, and our occasional weaknesses over our first 20 months. As several correspondents acknowledged, we have a continuing journey ahead of us – but our stakeholders, and HQIP itself, believe we have made an enormous amount of distance already.

ANNEX A

HQIP Stakeholder Survey – Summary Results

This survey was undertaken during June 2010. 2660 surveys were sent out to a cross-section of our stakeholder group, but which were overwhelmingly people who work in local clinical audit. Nonetheless those who have replied to questions on national audit are drawn from national audit work.

When the survey closed there were 432 forms on the system. 5 were from HQIP staff (pilot/test responses) and were deleted. A further 5 were deleted because the person completing the form had not given their name and job title and had not answered the 'compulsory' question asking them to give their professional role.

However, where the 'compulsory' role question was not completed, but the person had given a name and job title which indicated they did have a relevant role, the survey form was included.

In addition, one person did not give their name or job title, but gave their role as 'patient representative'. Their responses have also been included in the analysis.

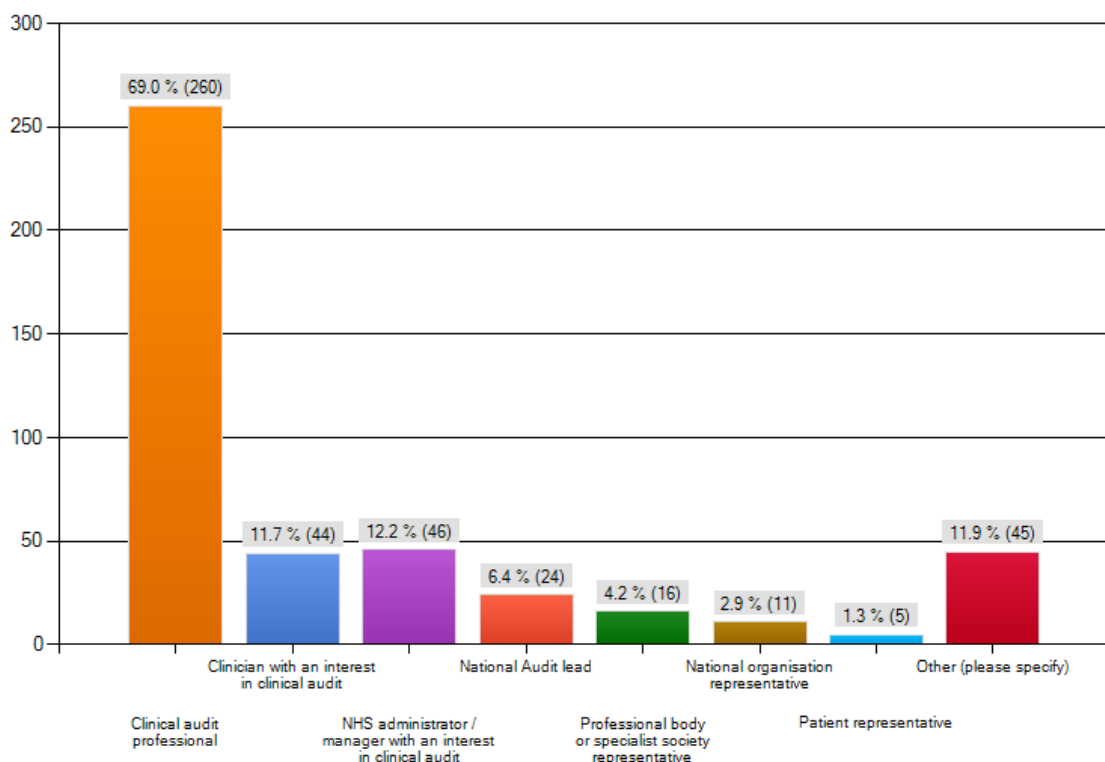
A total of 422 completed survey responses have been analysed, but as people chose not to answer all of the questions, the denominator varies throughout the results.

Likert scales were used and these are on a 1-10 basis, with 10 being the highest grade, 1 the lowest.

Professional role:

- 377/422 (89%) people responded giving 451 answers.

COMPULSORY QUESTION: How would you describe your professional role? (tick more than one if relevant and provide details when clicking 'Other')



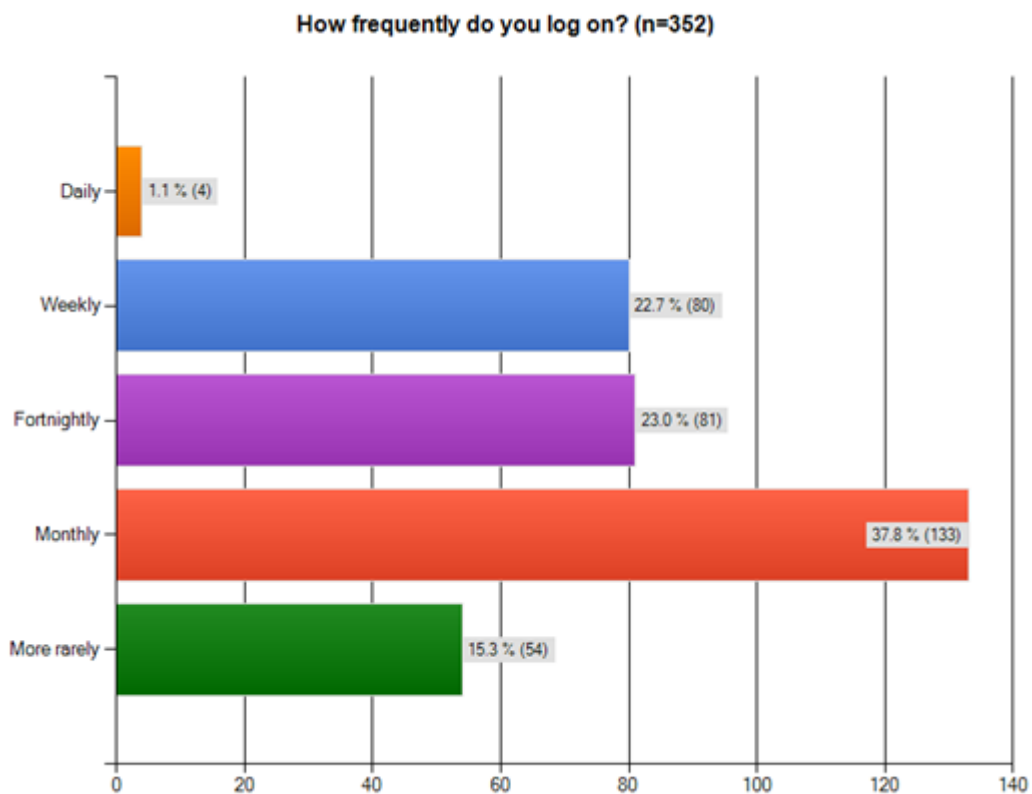
General

Contacting HQIP

- 116 / 372 (31.2%) have contacted HQIP with a query or for advice. Of that number:
 - 101 / 116 (87.1%) felt they had received a useful reply and
 - 104 / 116 (89.6%) received a reply within an acceptable timetable.

Website use and content

- 354 / 369 (95.9%) were aware of the HQIP website



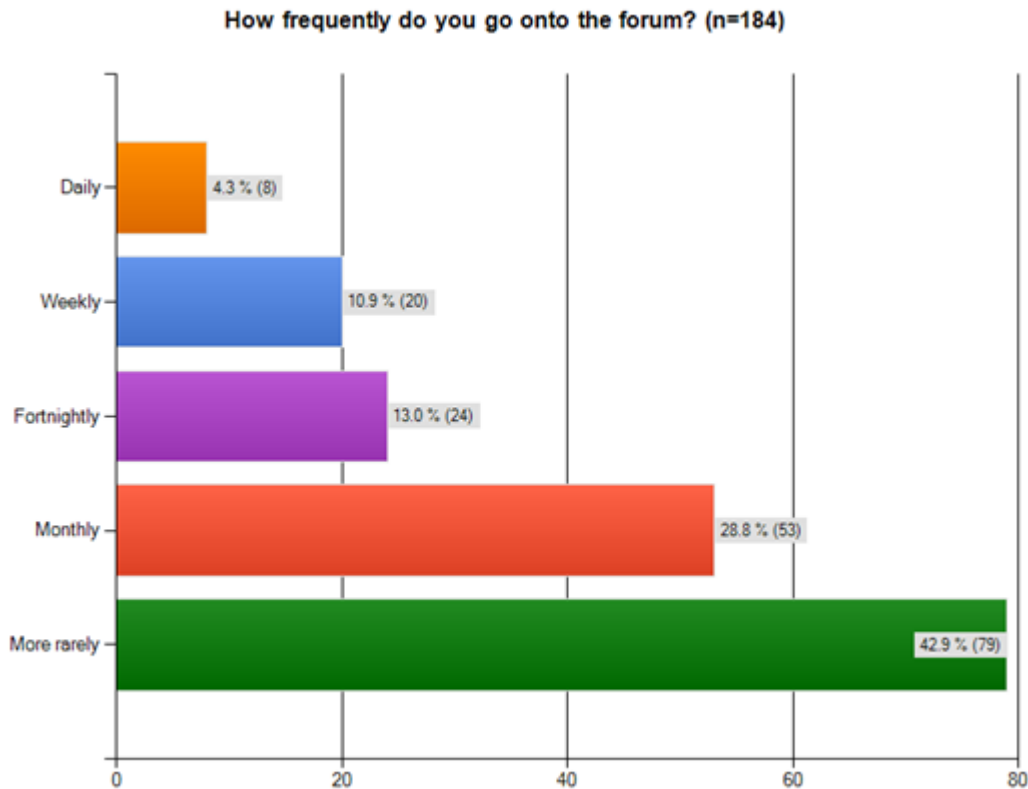
- 279 / 345 (80.9%) find the website easy to navigate and
- 333 / 345 (96.5%) find the website content useful.

HQIP e-bulletin

- 335 / 371 (90.3%) subscribe to the e-bulletin.
- 319 / 328 (97.3%) find the bulletin useful.
- 168 / 332 (50.6%) forward the e-bulletin on to others.
- 327 / 334 (97.9%) find the monthly frequency of the e-bulletin suits them.

NCAF

- 189 / 372 (50.8%) are registered with NCAF.
- 132 / 182 (72.5%) find NCAF a useful resource.
- 102 / 187 (54.5%) have joined a group or network on NCAF

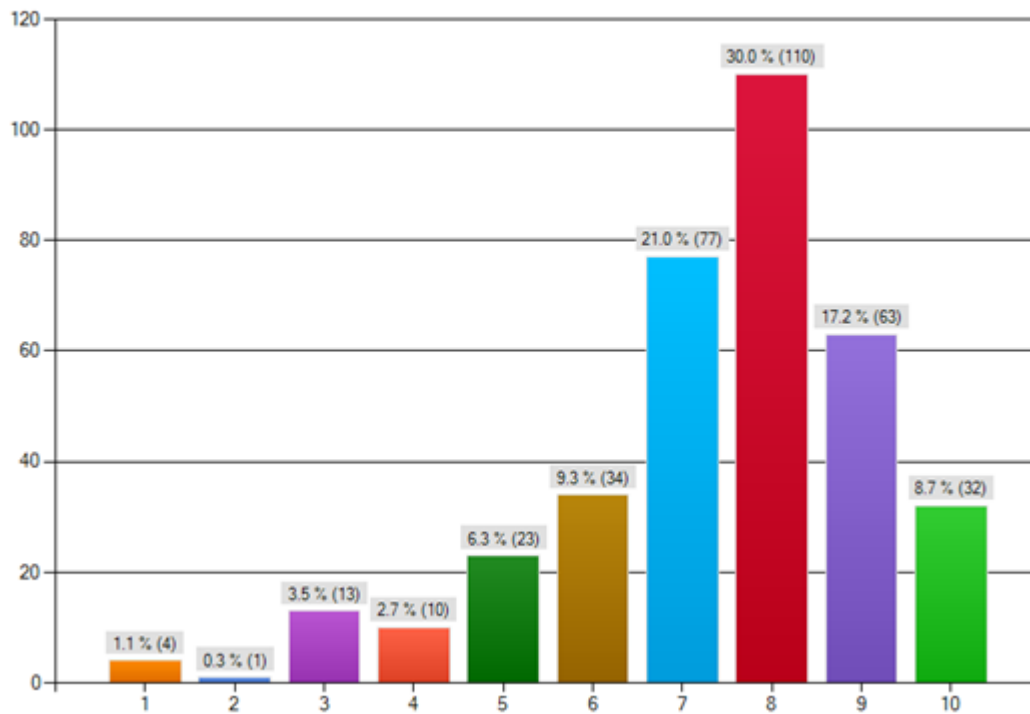


HQIP presence at meetings and events

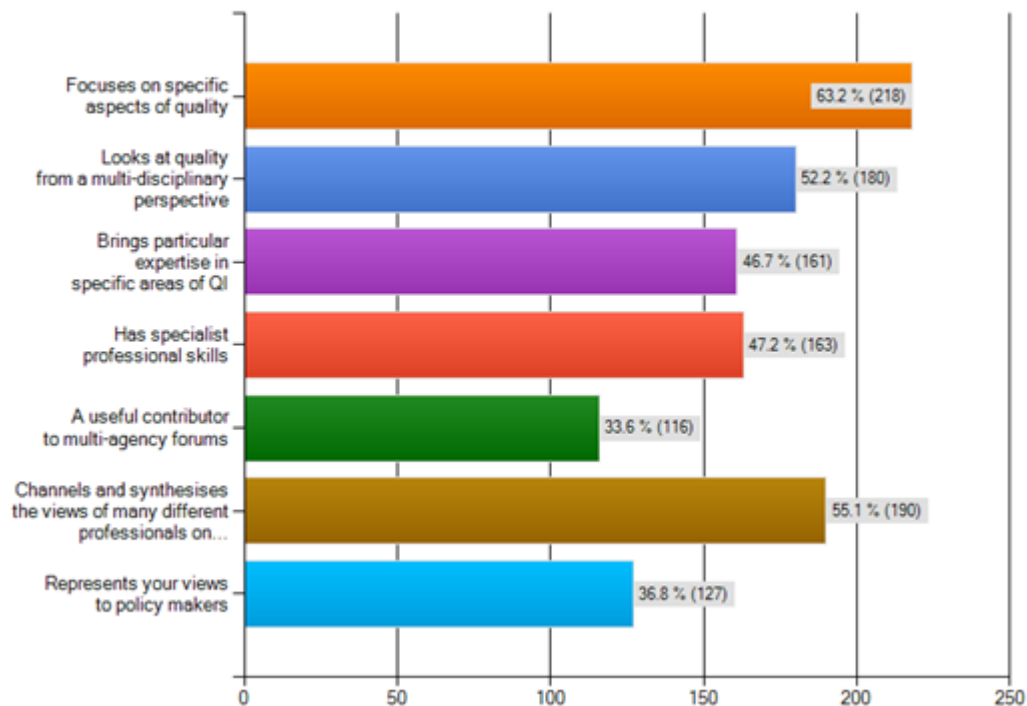
- 273 / 373 (73.2%) have attended an event where HQIP has been present, either as presenters or with the HQIP exhibition stand.
- 269 / 273 (98.5%) found the team approachable,
- 261 / 267 (97.8%) found the team knowledgeable,
- 242 / 261 (92.7%) had HQIP resource materials and good practice guides made available to them and
- 240 / 261 (92%) found it useful to be able to contact HQIP as part of an event.

SURVEY RESULTS & RESPONSE CONTINUES BELOW >>

The overall impact of HQIP: As a whole, how do you rate HQIP's efforts to re-invigorate clinical audit, taking into account all HQIP does, at local and national levels (out of ten)? (n=367)



What of the following attributes do you feel best describes the particular value of HQIP? Please tick as many options you feel apply/add others: (n=345)



Local clinical audit support

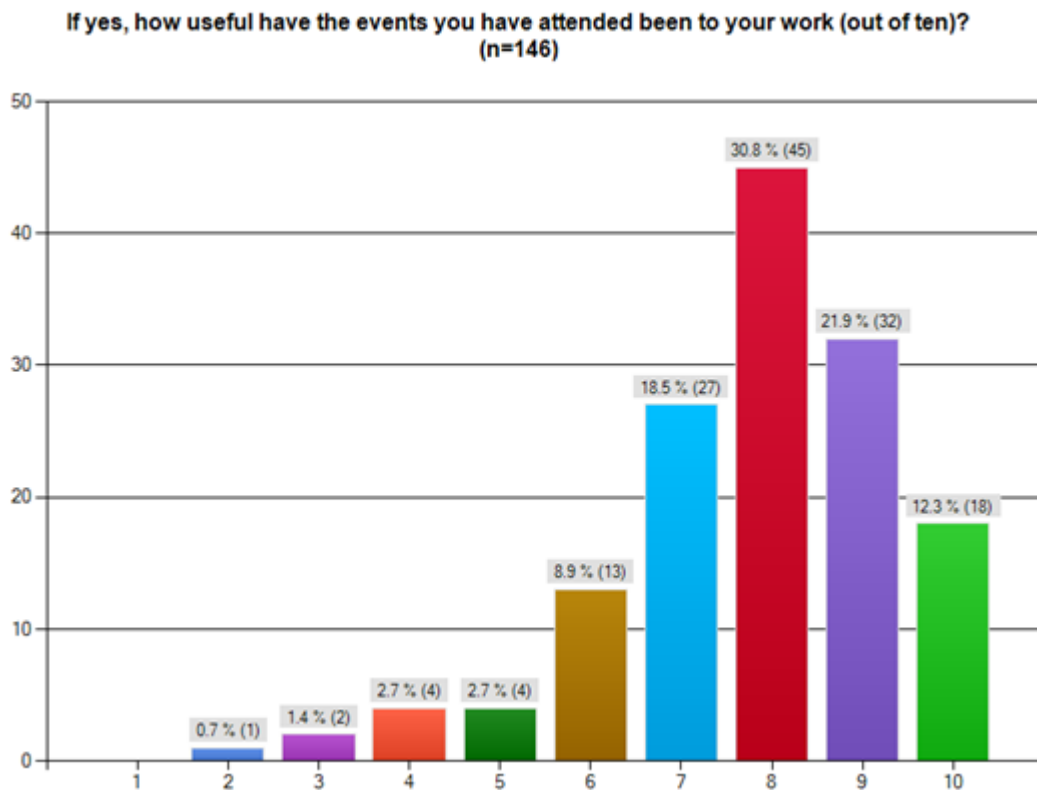
- 168 / 338 (49.7%) belonged to a local or regional clinical audit network or forum before HQIP was created. Of those that did not,
 - 48 / 164 (29.3%) now belong to an HQIP – supported regional network or forum.
- 168 / 215 (78.1%) were aware of HQIP attending the network to provide an update or speak about a requested topic and
- 160 / 173 (92.5%) found their attendance useful.
- 247 / 270 (91.5%) feel that the support provided by HQIP to local and regional networks is beneficial.

Clinical audit support tools

- 294 / 339 (86.7%) are aware of the clinical audit support tools available for download from the HQIP website.
- 218 / 291 (74.5%) have considered using the tools.
- 136 / 279 (48.7%) have used the tools to provide training, advice or guidance to colleagues and
- 203 / 279 (72.8%) have recommended the tools to colleagues.
- 79 / 219 (36.1%) gave suggestions about additional support tools they would like HQIP to develop.

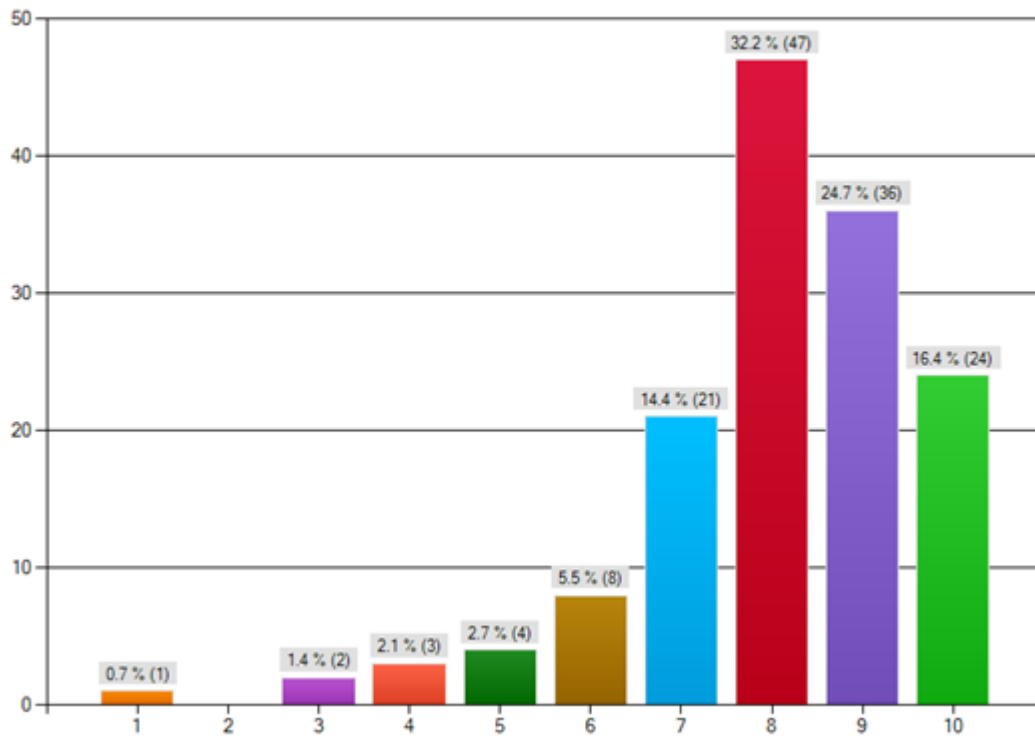
National audit commissioning and support

- 150 / 324 (46.3%) have attended events (subject-specific seminars and/or the two national conferences held to date) run by HQIP to support national audits.

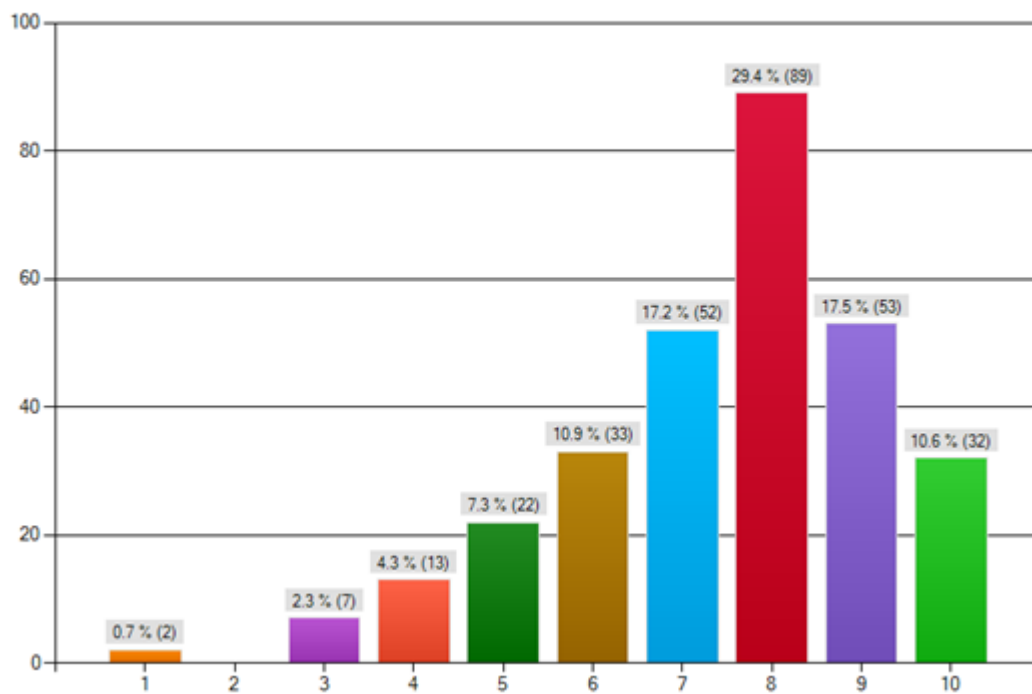


SURVEY RESULTS & RESPONSE CONTINUES BELOW >>

If yes, how would you rate the quality of these events overall? (n=146)

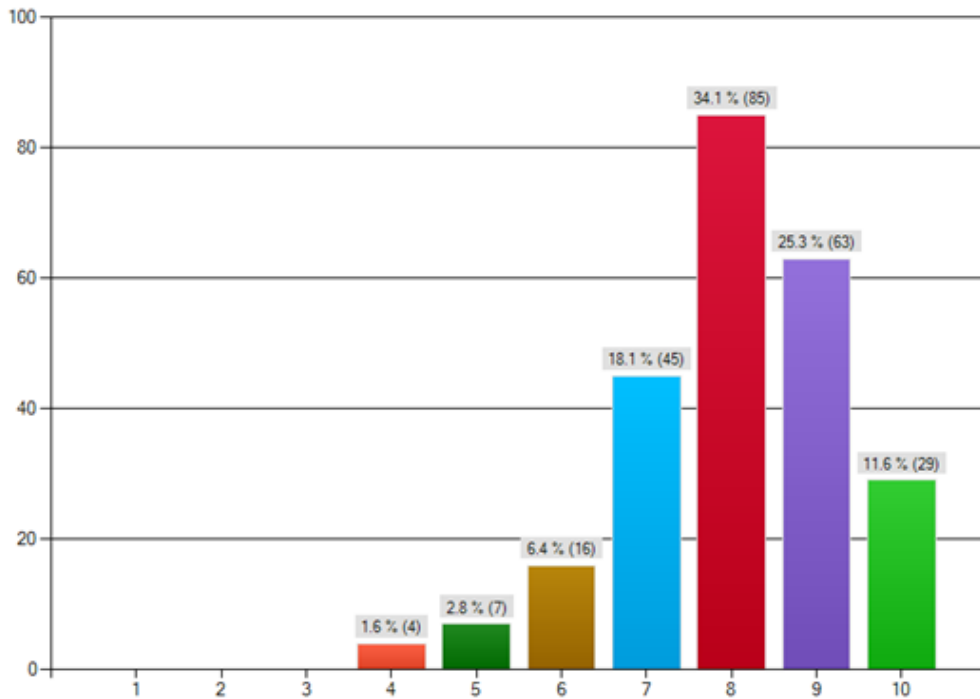


How would you rate the quality of HQIP's work as a whole (website, online services like NCAF, events) in terms of the opportunities it gives for those working in national audit, for learning and networking? (n=303)



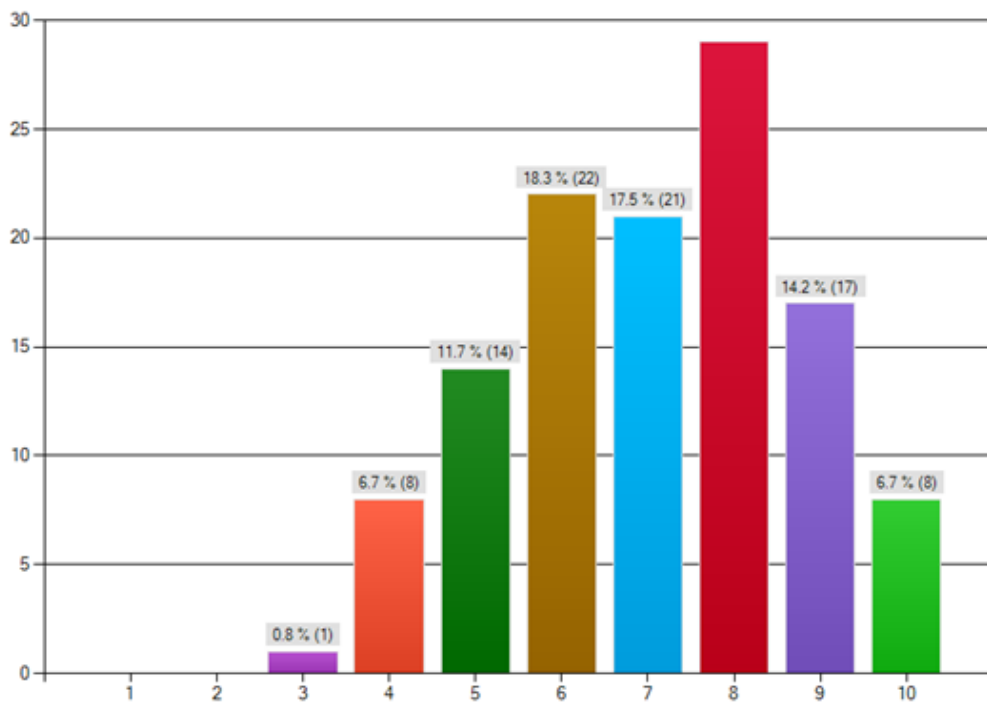
- 249 / 317 (78.5%) have seen the published guidance HQIP has produced for audit work.

How would you rate the quality of this published guidance HQIP has produced? (n=249)



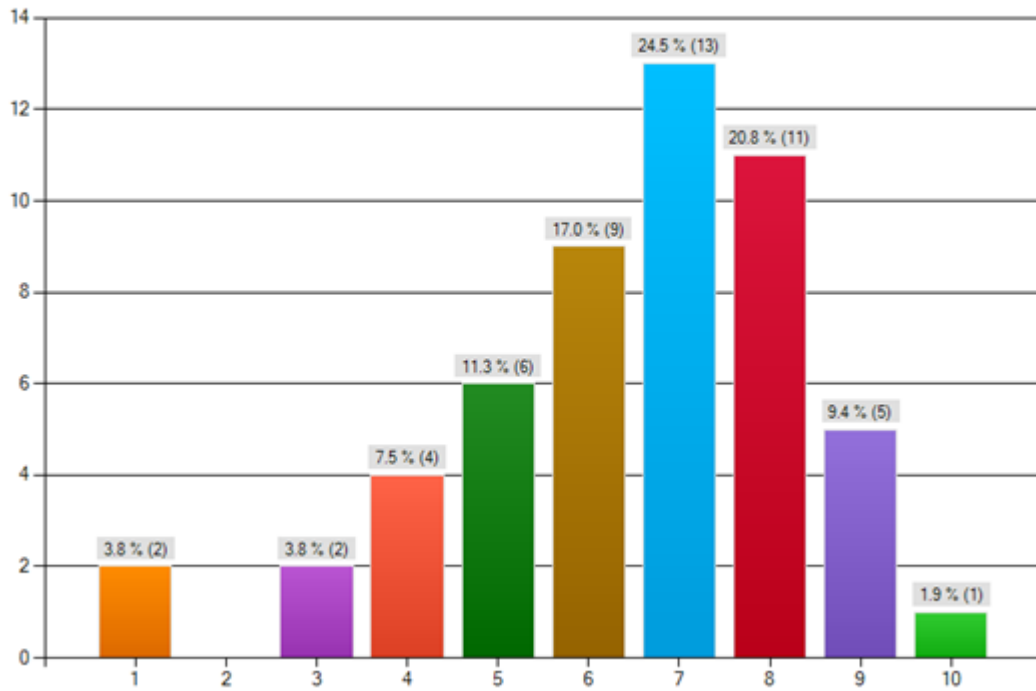
- 128 / 323 (39.6%) have seen HQIP information (online or in print) for the purposes of advertising and procuring audits, including media advertisements, tender documents and specifications.

How would you rate the quality of this information? (n=120)



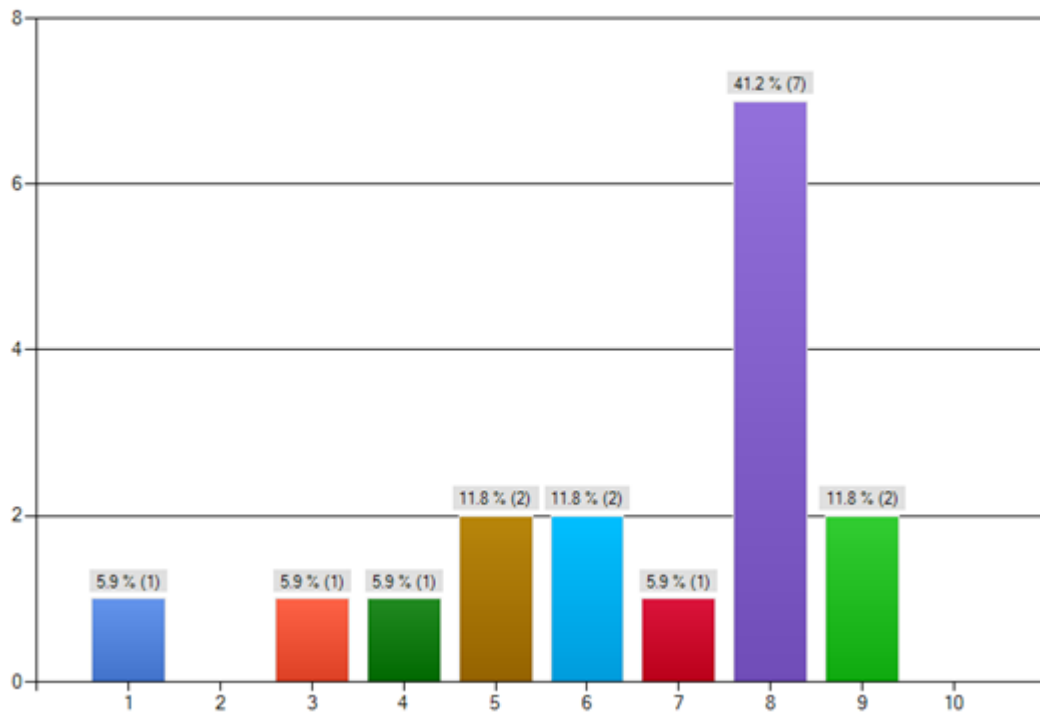
- 20 / 315 (6.3%) have at some point applied for funding from HQIP for a clinical audit project.

The Department of Health and their advisory committee, NCAAG, are involved in procurement alongside HQIP. How would you rate HQIP's contribution to the procurement process as a whole? (n=53)



- 16 / 323 (5.0%) have held an audit contract with HQIP.

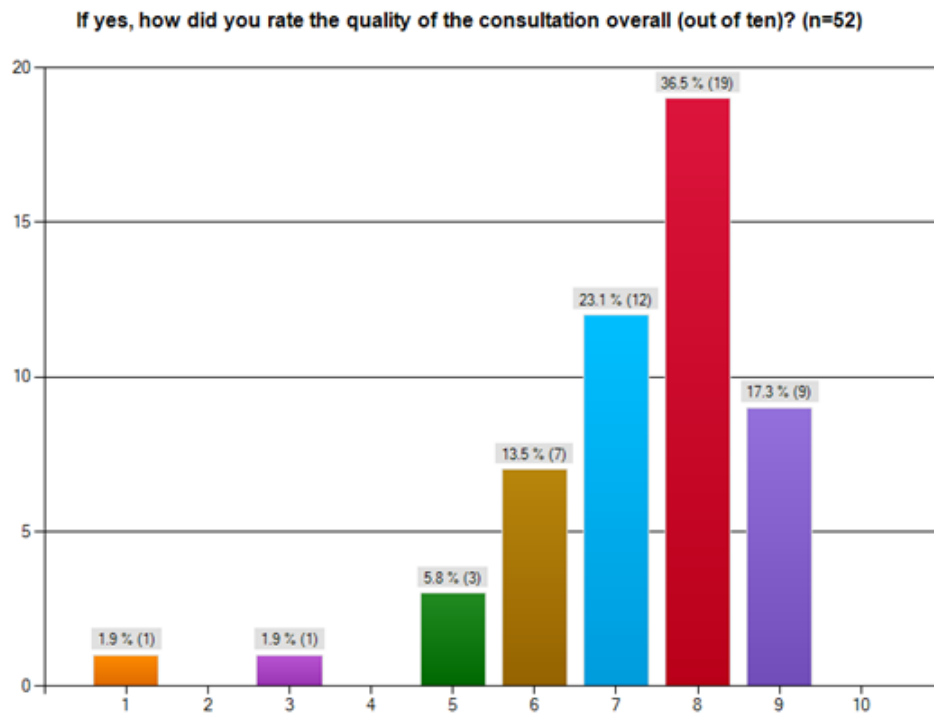
If yes, how would you rate overall HQIP's contribution to the management of your contract, taking into account the events above as well as contract management and procurement? (n=17)



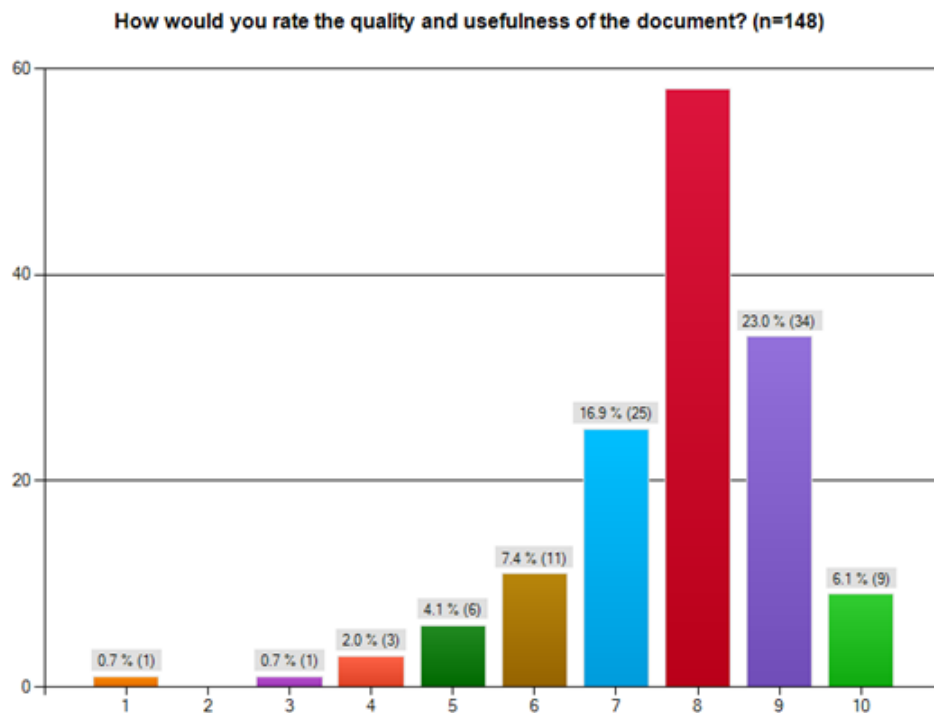
Development and Cross-cutting work

Developing the 'Criteria and indicators of best practice in clinical audit' (2009) document

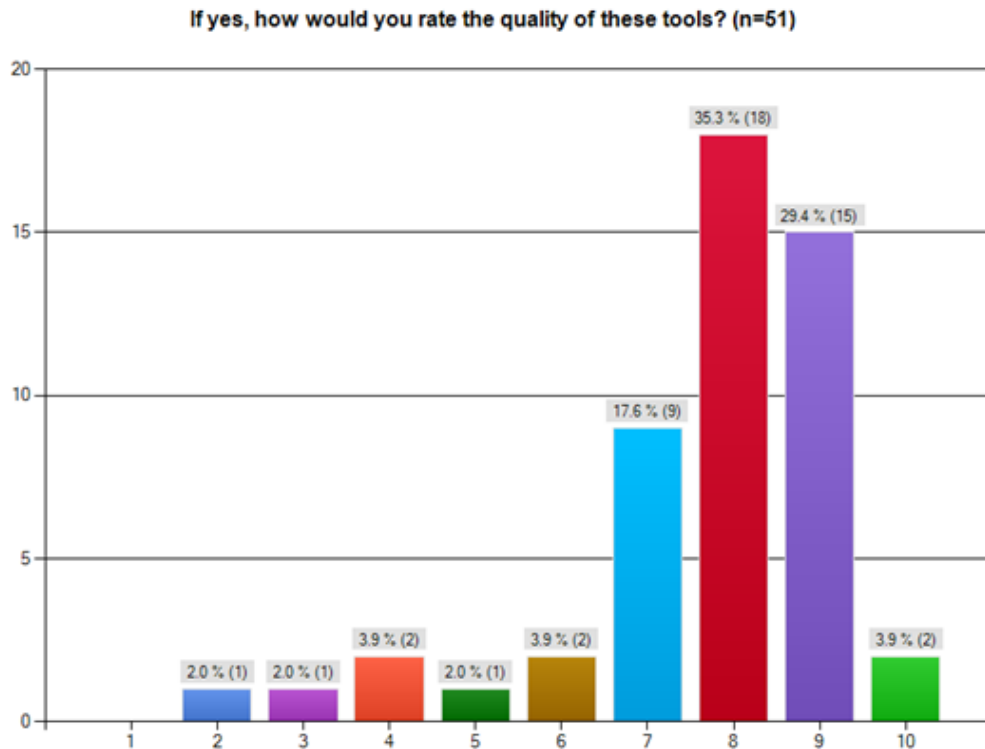
- 50 / 308 (16.2%) participated in consultation to develop this document, either at events or via email.



- 142 / 295 (48.1%) have used the document in their own work.

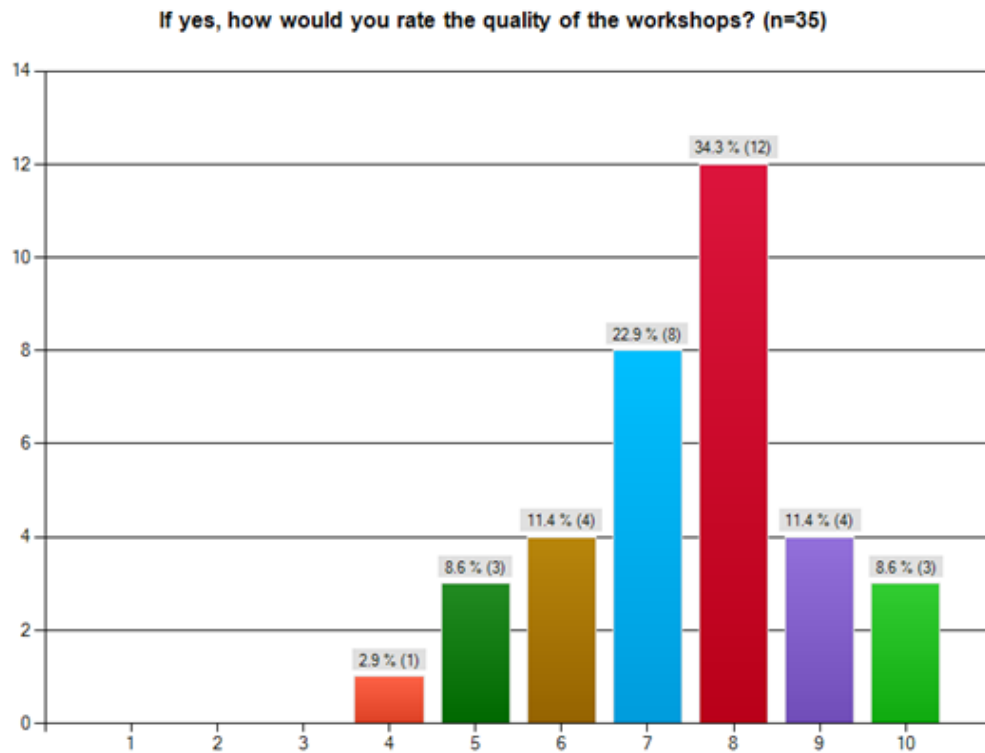


- 51 / 297 (17.2%) have accessed the complementary tools for this document (spreadsheet option and presentation template) that are available on the HQIP website.



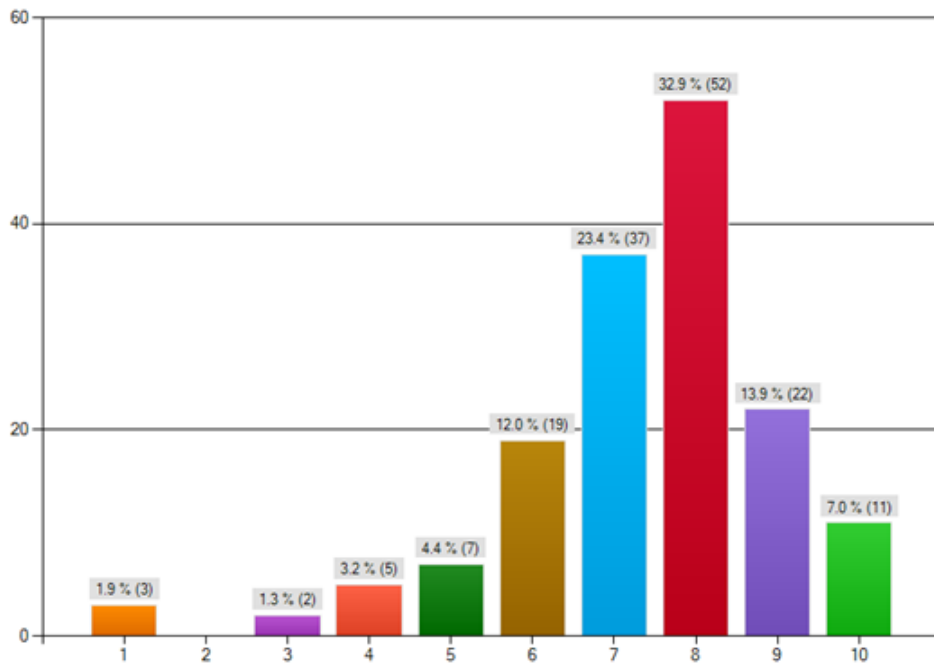
Development of Patient and Public Engagement (PPE) in clinical audit

- 36 / 305 (11.8%) had participated in one of the PPE workshops.



- 19 / 290 (6.6%) had participated in consultation with HQIP over PPE work in general
- 18 / 20 felt their contribution has been taken on board
- 176 / 296 (59.5%) were aware of HQIP's guidance 'PPE in Clinical Audit 2009'

If yes, how do you rate the PPE guidance? (n=158)

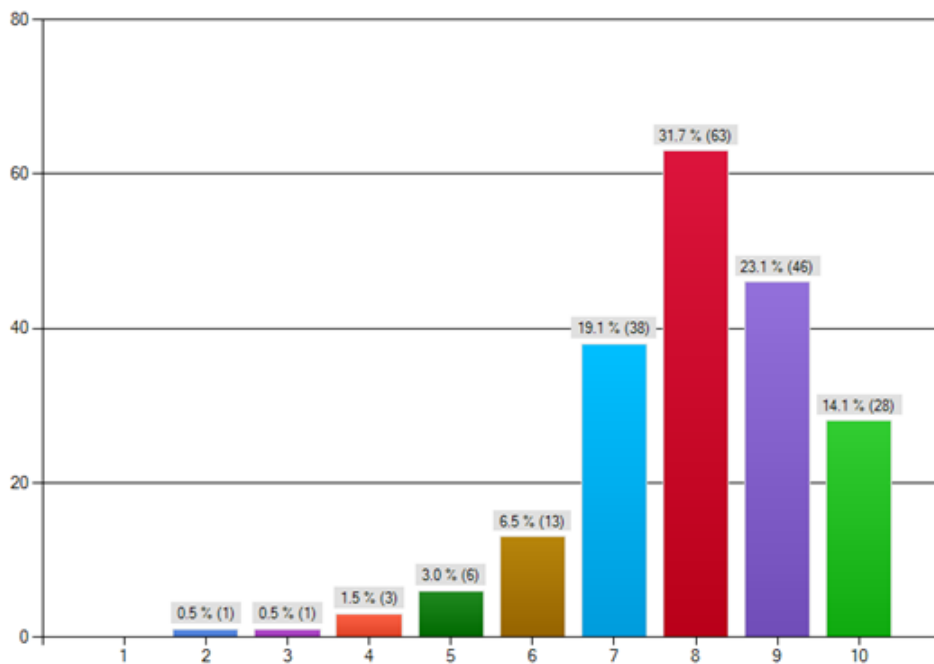


- 7 / 301 (2.3%) are part of the HQIP Patient Network
 - 1 / 6 rated the HQIP Patient Network at 5 / 10
 - 2 / 6 rated the HQIP Patient Network at 7 / 10
 - 3 / 6 rated the HQIP Patient Network at 8 / 10

Development of NHS Trust Board engagement in clinical audit

220 / 305 (72.1%) are aware of the HQIP guidance 'Clinical Audit: A Simple Guide for NHS Boards'

If yes, how would you rate the quality of the guidance? (n=199)

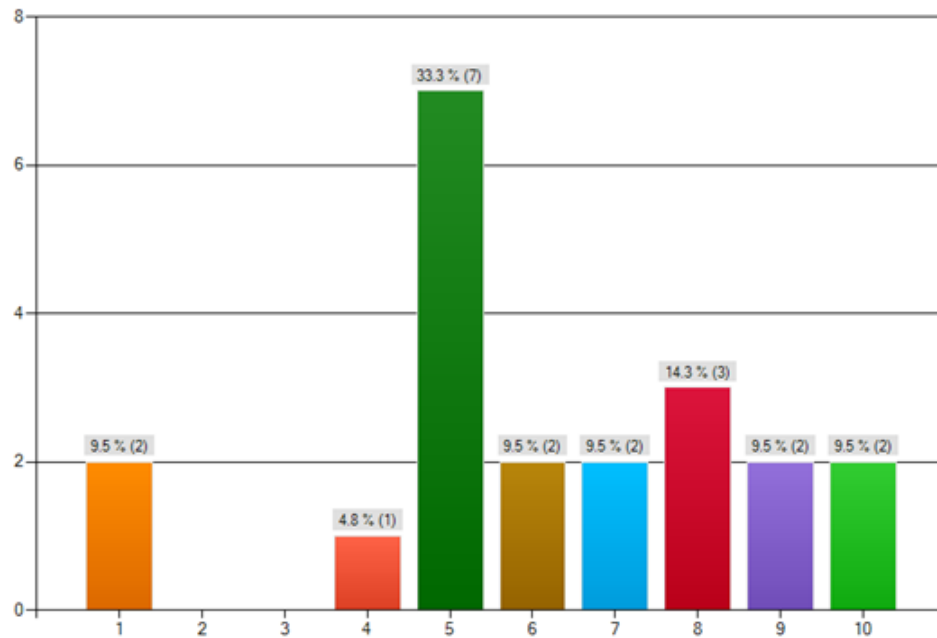


- 130 / 294 (44.2%) were aware of HQIP's NHS Boards engagement events

Development of GP involvement in clinical audit

- 14 / 303 (4.6%) have participated in this area of work

If you are aware of HQIP's GP engagement work to date, how would you rate the quality of this so far? (n=21)

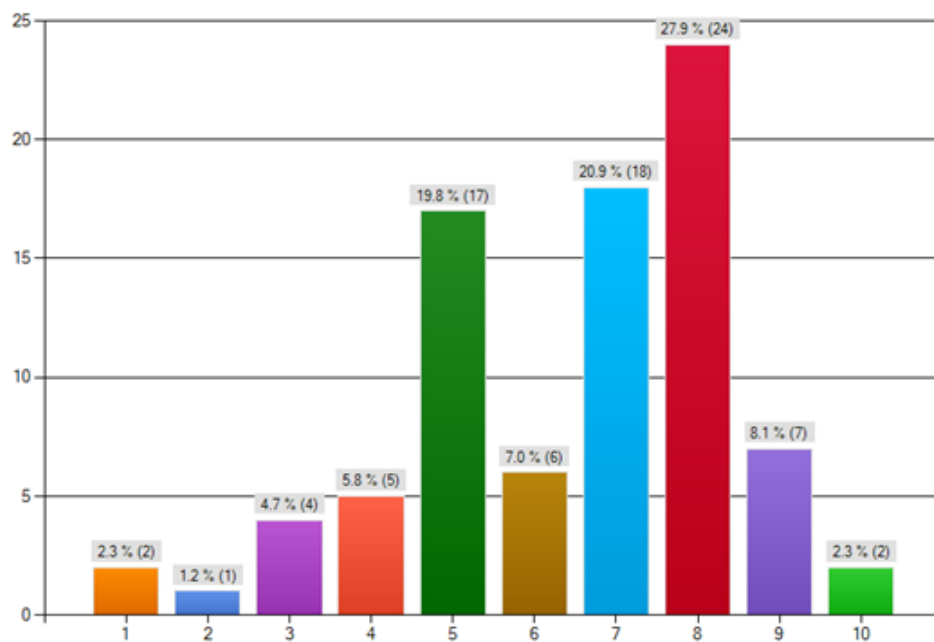


- 4 / 253 (1.6%) attended the GP workshop (May 2010)

Working with Professional Organisations in developing a model of accreditation

- 2 / 297 have participated in any of the workshops that HQIP arranged on accreditation

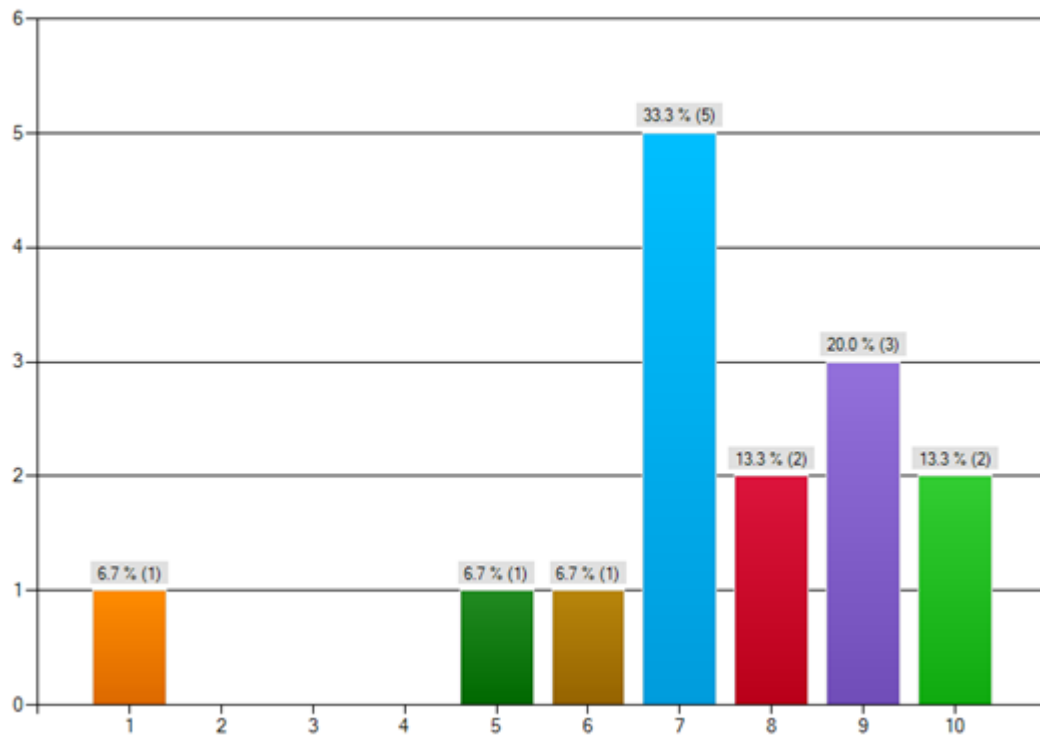
How would you rate HQIP's success in forming a consensus model across professions and groups? (n=86)



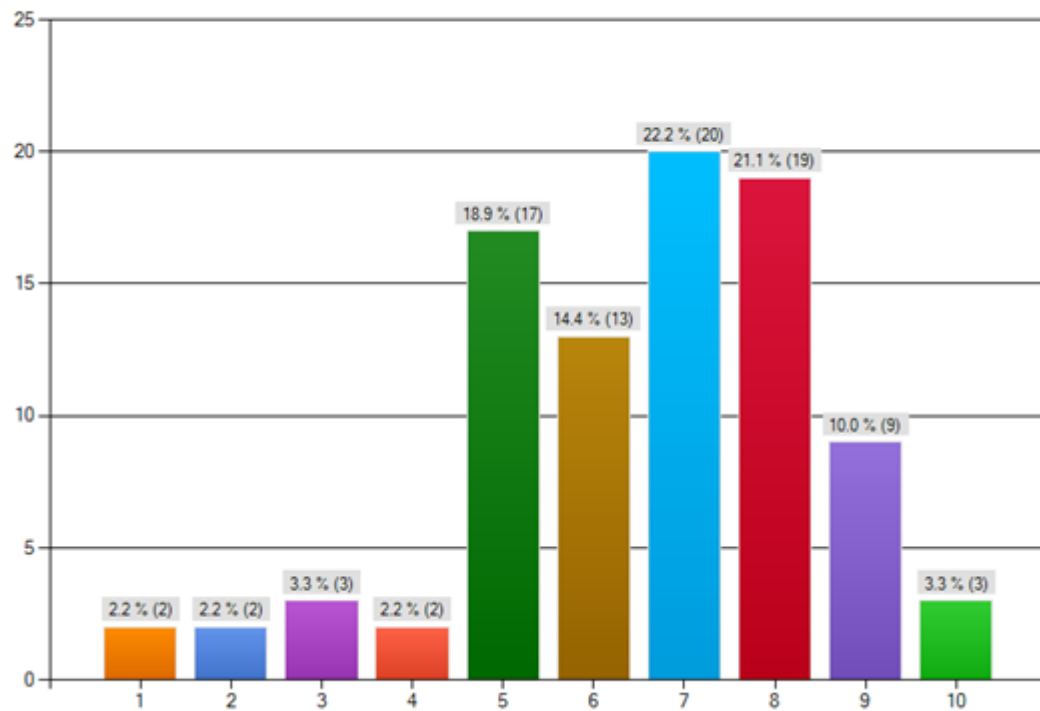
Working with the Royal Colleges in developing the role of clinical audit in revalidation

- 12 / 294 (4.1%) have participated in any of the workshops that HQIP arranged with the Royal Colleges

How would you rate the quality of HQIP's facilitation at these events? (n=15)



How would you rate HQIP's success in forming a consensus view across different specialties? (n=90)



ANNEX B: Findings from HQIP stakeholder interviews

Bryony Soper, Associate Reader with the Health Economics Research Group, Brunel University

These interviews were carried out in May-June 2010

Background

This report summarises the findings from a series of seventeen telephone interviews with HQIP stakeholders. HQIP was set up in April 2008, and the purpose of this exercise was to establish whether it has added value in clinical audit since then. The interviewees were chosen by HQIP and interviewed during May and June 2010: they included staff from NICE, national clinical audit providers, and members of the clinical audit community in NHS trusts, and they are anonymised here. Each interview lasted between 30 and 40 minutes. The areas of HQIP work covered included:

- Relations with NICE, NAGG, and NCAAG;
- National clinical audits and the NJR, including the tendering and procurement processes;
- Local clinical audit and local support, including the development of local clinical audit networks and the deployment of local clinical audit facilitators;
- HQIP guidance and tools, including online support through the NCAF and, potentially, through CAKE;
- Clinical revalidation, including start-up work with the RCGP;
- Service accreditation.

These are discussed in turn in what follows.

Relations with NICE, NAGG and NCAAG

- **NICE:** Relations with HQIP through the partnership enshrined in the Memorandum of Understanding have been positive and productive. HQIP has added considerable value to NICE's own work - providing improved feedback from the field about the use of NICE guidance in audit, facilitating engagement with national clinical audit teams, speeding up work in areas such as the development of GP engagement with NICE guidance, and providing expert help with the development of NICE quality standards. Contributory factors cited were HQIP's flexible working practices, positive and professional approach, close working relationship with the audit community, the usefulness of HQIP guidance, and the potential of CAKE.
- **NAGG:** HQIP's work to restructure and support NAGG has added value to NAGG's work. Early concerns about a possible overlap of roles have been dissipated; HQIP has provided NAGG with a structure by driving the local clinical audit agenda, building up local clinical audit networks, and ensuring that one representative from these feeds into NAGG. NAGG meetings are now better supported and more productive.
- **NCAAG:** This group was set up when HQIP came into existence in 2008. HQIP provides practical support for NCAAG meetings and deliberations, and this has worked well. On strategic issues NCAAG has the main lead, but does so in partnership with HQIP. Issues such as the relative elements of national audit and the role of NCAPOP-funded audits in implementing change have been ones where NCAAG and HQIP have had differing views which have been worked through openly. The added value of both bodies in working together to re-configure clinical audit is covered in the other sections of this paper.

National Clinical Audits

Tendering and procurement processes for the national clinical audits and other suppliers

A selection of the national clinical audit leads interviewed said that initially (2008-09) there had been little added value from the new tendering and procurement processes and that they had not helped to improve the quality of the national audits. Some stakeholders thought that the tendering process used for some national audits could have been better delivered by HQIP, although there was also understanding of the pressures which led to this shortfall.

Other problems were thought to lie (largely) outside HQIP control, and included:

- the expectations of potential suppliers, which were shaped by previous (and less rigorous) contracting arrangements
- time pressures
- lack of clarity about ultimate ownership of the process.

There was perceived improvement over time. HQIP learned from the first round about how they could improve on the details in the tender specifications. Efforts were made by HQIP and under the aegis of NCAAG, to improve the rigour of the procurement and commissioning process. Another of HQIP's suppliers, HQQ, saw a "dramatic" improvement over the last year. The more recent procurement process for multi-site audits was seen as "quite straightforward" and "not too onerous".

However, more fundamental concerns were raised about the requirement to do the tendering exercise, and whether this provided a context in which HQIP *could* add value. There were strongly expressed views that it did not, and that it made little sense to put a national audit out to tender when there was, in practice, only one possible bidder because the relevant specialist society/professional body was the only available organisation with the expertise and the necessary clout with clinicians to undertake the audit successfully. This lack of competition did not assure quality - that required an alternative approach such as an audit of audits. The shortness of the interval between tendering exercises was also questioned.

Management of contracts

A related issue was the management of contracts. Among the interviewees who mentioned this, there was a general view that HQIP had added considerable value and had, through this mechanism, helped to improve the quality of the audits. For example:

- NDA The national clinical audit lead was very positive about the engagement of HQIP in tender negotiation and consultation on priorities for a new version of the National Diabetes Audit – it had led to a big change and improvement for the NDA. These positive gains derived from the greater professionalism of HQIP (compared with its predecessors), their business-like approach, and their abilities to organise a consultation on priorities that involved patients effectively: there had been "a genuine quantum leap in the scope" of the new audit.
- PICA Net HQIP was PICA Net's "best funder to date", the most interested, good at keeping in touch, and intelligent and supportive. HQIP had provided strong support for the revamp of PICA Net IT.

NJR

Compared with the previous direct management by DH, the NJR had made much more progress under HQIP and HQIP had provided good support for the Steering Committee and its Acting Chair. Specific drivers were HQIP's clearer understanding of what the NJR was trying to do, and keener interest in facilitating progress. HQIP has used its skills and expertise to support the NJR development agenda and is helping to make developments happen, such as work on handling outliers.

Other HQIP support

- Coordination There was a general view that better coordination between national audits was needed but a divergence of views about HQIP's role in this. Some interviewees mentioned the added value provided through HQIP forums or HQIP staff's knowledge of other audits.
- HQIP guidance and tools These have not been much used or valued by the national audits
- HQIP's view of audit. HQIP's broader view of audit compared with its predecessor had added value

Local clinical audit

Developing local audit networks and support

There was enthusiasm for the work HQIP has done on local clinical audit: most interviewees were positive about the added value from the local presence of HQIP and they hoped this would continue. Interviewees valued the raised profile for audit that HQIP has achieved and the support this gave local work on clinical audit, the facilitation of local networks provided by HQIP, and the ease of access to HQIP staff, tools and guidance. But the need for local support varies. Where local audit practice was already well developed there was a view

that HQIP support had added less. More generally, there were concerns that the added value of HQIP's work to support local audit would be undermined by the increasing pressures on local audit staff: "Where there have been staff cut-backs the first thing that goes is clinical audit".

HQIP guidance and tools

At the local level these sorts of materials had not been available before and so they had added considerable value, although there is some variation in quality and more 'marketing' was needed. Local audit staff found them a useful resource. Interviewees specifically commented on the usefulness of the recent trust board guidance and the guidance on involving patients and the public. The added value came, in part, because the guidance originated from a respected outside organisation. NICE staff said that if HQIP had not produced this sort of guidance they would have had to produce something similar, and that they would be working on future guidance with HQIP.

Online support

The NCAF was seen as useful by those who knew about it, though many did not, which limited its added value. Monthly e-mail updates to those in the field to, e.g. demonstrate new tools, were also useful. CAKE had exciting potential

Developing audit as a profession

There was general agreement that this was a good thing, but mixed views about what HQIP had achieved, or could do, and the possible implications. Some felt HQIP had already added value by confirming that clinical audit is important and by developing an identity for the profession. Others were concerned about the implications of providing training for staff given the few resources currently available, or that staff might not want training, or that people would get left behind through lack of access or availability of funding. There was a need to recognise experience. Some thought that HQIP had the potential to do an "outstanding" job here, but that would have to involve government support and the prior creation of a Quality Society similar to those in other countries.

Links between local and national clinical audit

There was limited perceived added value here, and many gaps were identified. Some national clinical audit leads saw no links between national and local audit. There were concerns about how trust boards support and prioritise audits (favouring national audits over local work), and about the impact of the new quality accounts. There were concerns about using scarce local resources to collect data for national audits that offered little return to trusts, exemplified in the lack of liaison between the CHD national audit and the ambulance services, which provide input but get no data on patient outcomes in return.

The use of clinical audit in clinical revalidation

HQIP ran two workshops, a stakeholder engagement exercise and pulled together a final, agreed guidance document. Two interviewees commented on this process. In terms of the practical support HQIP provided, the intellectual guidance they offered, and the difficult task of brokering the very disparate initial positions of the different colleges, both interviewees were clear that HQIP had added value, and that an agreed final document would not have been possible without them. Both also commented that initial discussions at the first workshop had been somewhat unstructured and nebulous, but by the second workshop discussion had become much more focused. The final product was seen as helpful – "HQIP got the principles in place". It provided a general framework within which responsible officers, quality assessors, clinicians and trusts could now operate, a gold standard that could provide a starting point for further work by individual colleges.

HQIP recently funded and facilitated initial work to help RCGP develop a portfolio of work to support GPs through appraisal. There was definite added value: HQIP had driven the agenda, facilitated the exploratory meeting well, and been generally supportive -- the college was in a stronger position as a result.

Service accreditation

HQIP built on previous work, running a workshop and supporting the development of a report on a core model for service accreditation. Two interviewees commented on this work and their views differed slightly. One said that the workshop was well done, professionally run and resulted in the efficient production of outcomes which culminated in a report to the National Quality Board, and provided a ringing endorsement of HQIP's performance and continued role in this work. Another also thought the processes had been well handled, but was less convinced about the underlying rationale for the exercise – the workshop had not addressed fundamental questions such as whether the NHS could afford service accreditation, and, therefore, what role the colleges should play. The extent to which this work had added value depended, in the end, on whether it was good for the NHS.

General comments and conclusion

A brief summary such as the above cannot do justice to the richness and complexity of interviewees' comments about particular areas of HQIP's work. Nor can it capture the numerous remarks about the helpfulness, ability and interest of HQIP staff, and about the openness of HQIP as an organisation.

Several issues stand out: the strong relations that HQIP has developed with key national stakeholders and with some local stakeholders; the widespread recognition of the work HQIP has done to strengthen local clinical audit; the difficulties and inadequacies of the tendering and procurement processes for national clinical audits, and the marked contrast with the gains in quality achieved through the contracting process and associated discussions with HQIP; the need for audits, once developed, to be able to rely on the continued active leadership of clinicians and professional bodies *and* on the active participation (including subscription) of relevant NHS providers; the related needs to ensure that national and local clinical audits meet the requirements of the NHS and its patients, and to strengthen links between national and local clinical audit; the need to strengthen and adequately exploit links between clinical audit and the research community seeking to use audit data.

HQIP has raised the profile of audit and, in this respect, has achieved more in two years than its predecessors in the last decade. But in many areas its work is still beginning, two years is a very short period for such an organisation to prove its worth. Acronyms in report

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| CAKE | Clinical Audit Knowledge Exchange |
| HCC | Healthcare Commission |
| HQIP | Healthcare Quality Improvement Partnership |
| NAGG | National Audit Governance Group |
| NCAAG | National Clinical Audit Advisory Group |
| NCAF | National Clinical Audit Forum |
| NCAPOP | National Clinical Audit Patients Outcome Programme |
| NDA | National Diabetes Audit |
| NICE | National Institute for Health and Clinical Effectiveness |
| NJR | National Joint Registry |
| NHS IC | NHS Information Centre |
| PICANet | Paediatric Intensive Care Audit Network |
| RCGP | Royal College of General Practitioners |