HQIP Position Paper

Resetting audit and quality improvement in UK postgraduate medical training and specialty selection

Purpose

This position paper sets out HQIP's recommended approach to how clinical audit and quality improvement should be taught, supported, assessed, and rewarded across UK postgraduate medical training. It is designed to be endorsed by the Medical Royal Colleges and used to influence postgraduate curricula, workplace learning, and specialty selection frameworks.

Executive summary

Audit and quality improvement are central to safe care and effective clinical governance. They are also widely used in specialty recruitment shortlisting. The evidence base summarised in this paper[i] shows that current selection incentives encourage high volumes of standalone, trainee-led projects and often reward activity and leadership roles over collaboration, rigour, sustainability, and patient benefit.

- Most specialty programmes examined use audit or quality improvement within shortlisting.
- The mean proportion of shortlisting points allocated to audit and quality improvement is around one tenth, with wide variation between specialties.
- Programmes commonly require completion of at least one closed loop project to obtain maximum points, and many specify leading the work to score at the top level.
- The estimated project volume associated with shortlisting requirements is substantial, rising sharply when all applicants are considered, not only those appointed.

HQIP's position is that audit and quality improvement should remain core elements of postgraduate education. The system needs reform so that curricula and selection frameworks reward meaningful improvement capability, validated contribution, and impact. We propose a national standard for evidencing improvement work and a shift in recruitment scoring that prioritises participation in national clinical audit and other agreed priority programmes.

The case for change

Why this matters for patients and the NHS

Audit and quality improvement exist to improve care. When they become primarily a currency for professional progression, the system risks producing work that is performative, duplicative, and disconnected from service priorities. It also brings clinical consequences, including poor handover as trainees rotate, discouraged collaboration, and fragmented improvement effort. This creates avoidable burden for clinical teams and audit departments, and it limits the learning value for doctors in training. Many trainee projects do generate valuable local learning and improvement. This review highlights opportunities to better support and incentivise trainees so their efforts contribute more consistently to meaningful and sustained improvement.

Key insights from recent evidence

A recent cross sectional scoping review mapped how audit and quality improvement are used in UK specialty training shortlisting. It highlights four issues that require action.

Scale: audit and quality improvement are used widely across specialties, generating high volumes of projects.
Misaligned incentives: scoring frameworks often incentivise quantity, closed loop completion, and individual leadership roles, rather than sustained team based improvement activity.
Ambiguity: many selection processes treat audit and quality improvement as interchangeable, which blurs expectations and encourages box ticking.
Equity: access to supervision, data, and improvement infrastructure varies materially between placements, creating uneven opportunity. This can be most acute between smaller and rural district general hospitals and large academic centres, where access to training, supervision, and data support is often linked to local funding.

HQIP position

Core statement

Audit and quality improvement should remain central to postgraduate training. The system should prioritise patient benefit and learning over sheer volume, and recognise team based contribution as strongly as individual leadership.

HQIP defines meaningful audit and quality improvement activity in training as work that is:

- Purposeful and linked to patient benefit or safety.
- Aligned to organisational priorities or agreed national priorities.
- Supported through supervision and access to improvement capability.
- Governed proportionately, including information governance and data quality. Formal registration and supervision protect patients, improve data quality, and ensure learning is captured and acted on.
- Sustainable, with learning captured and handed over across rotations.
- Fair, with comparable opportunity regardless of geography or setting.

Recommendations for postgraduate curricula

A staged improvement capability model across all specialties

Curricula should set clear developmental expectations that build over time. Early stage trainees should be expected to participate and learn methods. More advanced trainees should be expected to lead and sustain change at service level.

- Early stage training: participation in supervised audit or improvement activity, understanding measurement, standards, and governance.
- Middle stage training: applying improvement methods, working in teams, engaging stakeholders, and interpreting clinical audit data.

- Senior stage training: leading or co-leading service level improvement with measurement strategy, sustainability planning, and spread where appropriate.

Minimum expectations for training environments

Training environments should provide the infrastructure needed for meaningful improvement work. This should be treated as a quality requirement for training. Educational supervisor sign off is already part of many existing training processes, including ARCP. Greater consistency in project quality is more likely to come from better access to training, coaching, data support, and clearer local guidance on improvement priorities than from additional layers of formal sign off.

- Access to an audit or quality improvement function or equivalent capability.
- Named supervision for improvement work.
- Support for measurement and data access.
- A published set of local priorities so trainees can plug into existing programmes.
- Simple processes for project registration, governance, and handover.

Recommendations for specialty selection and recruitment

Reform points to prioritise impact and alignment

If audit and quality improvement remain part of selection, scoring must evolve to reflect their true purpose. Points should prioritise contribution to recognised programmes that are more likely to deliver sustainable impact, including national clinical audit.

National standard for evidence: the Improvement Evidence Record

HQIP recommends a single national standard evidence record that can be used across specialties. This reduces burden, improves fairness, and provides recruiters with consistent evidence. The record should be supervisor validated.

Model scoring approach that any specialty can adopt

HQIP proposes a common structure for scoring that specialties can map into their own processes while preserving local autonomy.

Highest recognition
Validated contribution to an established, priority aligned audit or quality improvement programme at national, regional, system, or organisational level. This includes national clinical audit and registries where opportunities are accessible, alongside trust or system priority programmes with clear aims, governance, and continuity.

Recognition
Validated contribution to supervised audit or quality improvement activity that demonstrates sound method, learning, and appropriate governance.

Scoring should increase where there is evidence of patient benefit, sustainability beyond a single rotation, and effective handover. A single strong example should score more than multiple weak examples. Project counting should be discouraged.

Safeguard on implementation

Any changes to scoring should be introduced in step with the development of accessible routes for trainees to contribute to priority programmes, so we avoid unmet demand, bottlenecks for national providers, or inequity between specialties and training environments.

Measures of success

- Fewer duplicated, low value projects, with better continuity and handover as trainees rotate.
- A better trainee experience, with clear expectations, consistent supervision, and straightforward routes into meaningful work.
- Increased contribution to priority programmes, including national clinical audit, with stronger team based participation recognised and rewarded.
- Fairer opportunity across training environments, with reduced variation in access to support, data, and improvement infrastructure.
- More trainee audit and quality improvement activity formally registered within Trust governance systems, aligned to the Trust audit and improvement agenda, and reported in a way that captures learning and supports sustainability.
- Stronger evidence of sustained improvements in care, with impact that persists beyond individual rotations.

Audit and quality improvement remain essential to professional practice. The system should now strengthen and align how education and selection recognise this work, so that trainees are supported to develop meaningful capability and deliver patient benefit across all settings, including primary care. HQIP invites the Medical Royal Colleges and national recruitment leads to endorse this position and work jointly to implement the national evidence standard and priority based scoring, ensuring that audit activity in general practice and wider community services is properly recognised, supported, and linked to local and national priorities.

Evidence base

This position paper is informed by a cross-sectional scoping review undertaken by HQIP and collaborators: The use of audit and quality improvement as selection criteria in UK postgraduate medical specialty training.

[i] The evidence review summarised in this section forms part of a journal article currently submitted for publication. The full citation will be added once the article has been published.