

Excellence in Clinical Audit Awards 2026 Announcement: Patient Safety Winners

Thursday 25 June 2026, 12.45-1.30pm

THIS EVENT STARTS AT 12.45pm



Discover all the #CAAW26 events:

Scan the QR code or visit
www.hqip.org.uk/caaw26

Excellence in Clinical Audit Awards 2026 Announcement: Patient Safety Winners

Welcome to Clinical Audit Awareness Week, 22-26 June 2026: www.hqip.org.uk/caaw26

Today's agenda:

- **Welcome and Award Announcements**

Tina Strack, Associate Director, HQIP

- **Winning Project Presentation**

- **Clinical Audit and Patient Safety**

Vicky Patel, Clinical Effectiveness Manager, The Rotherham Foundation Trust

- **Q&A**



Before we start...

Being seen and heard

- Event recorded
- Mics off for background noise
- Cameras on, if you are happy to

Asking questions

- Use the Q&A to post your questions
- Contact us via HQIP website if Q&A unavailable for you

Recommendations

- Laptop/PC, not phone
- Try browser version, not app
- If needed, rejoin using rejoin button on screen or original Teams link

Don't forget to share on social media: #CAAW26

#CAAW26



**EXCELLENCE IN CLINICAL
AUDIT AWARDS**

*Shining a Light on Data-Driven
Healthcare Improvement*

Patient Safety Award

CLINICAL AUDIT AWARENESS WEEK 2026

Improving lives with healthcare data



HQIP

Healthcare Quality
Improvement Partnership

#CAAW26



**EXCELLENCE IN CLINICAL
AUDIT AWARDS**

*Shining a Light on Data-Driven
Healthcare Improvement*

AND THE RUNNER UP IS...

CLINICAL AUDIT AWARENESS WEEK 2026
Improving lives with healthcare data

 **HQIP** Healthcare Quality
Improvement Partnership

Patient Safety Award 2026, Runner-Up

Christine Wendam, Sandra Lennon and the Clayponds Hospital Team, West London NHS Trust

Breaking the Fall: Reducing Harm from Inpatient Falls at Clayponds Rehabilitation Unit, West London NHS Trust



#CAAW26



**EXCELLENCE IN CLINICAL
AUDIT AWARDS**

*Shining a Light on Data-Driven
Healthcare Improvement*

AND THE WINNER IS...

CLINICAL AUDIT AWARENESS WEEK 2026
Improving lives with healthcare data

 **HQIP** Healthcare Quality
Improvement Partnership

Patient Safety Award 2026, Winner

**Dermatology Department, Sandwell and West Birmingham
NHS Trust**

Monitoring skin cancer MDT outcome compliance



Patient Safety Winner:

Dr Karisma Sharma, Core Surgical Trainee

Dr Sonika Nayyar, Dermatology Registrar



**Sandwell and
West Birmingham**
NHS Trust

Excellence in Clinical Audit
Awards 2026
Skin cancer MDT Outcomes Audit

Dr Karisma Sharma, Dr Sonika Nayyar

*With thanks to: Dr Michelle Thomson,
Anne Rutland and Aimee Noone
Birmingham Skin Centre Team*

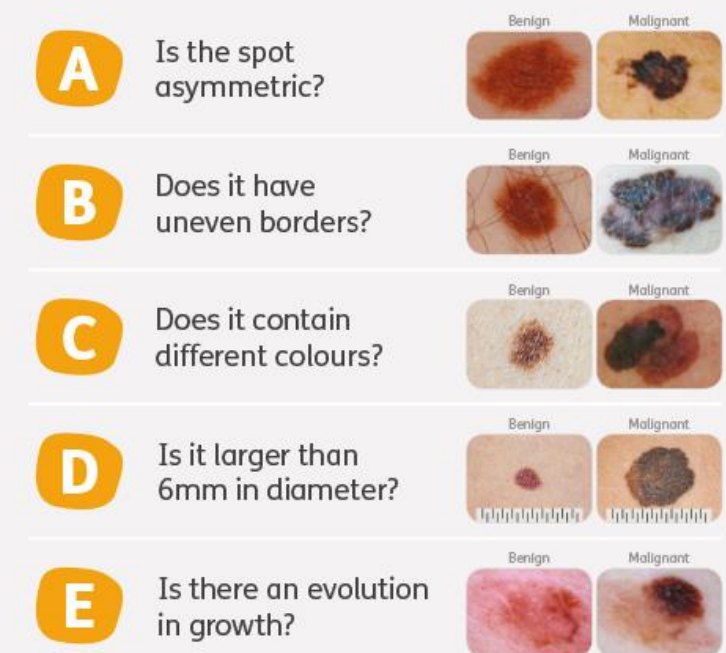


Skin Cancer in the UK

- Skin Cancer is the most prevalent cancer in the UK comprising of 1 in 4 new diagnoses, with 19, 392 cases of the melanoma sub-type a year, with diagnoses having an upward trajectory [1, 2]
- In 2020, the UK was estimated to have the 9th highest incidence rate of melanoma [3]
- Older patients are adversely affected, driven by an ageing population and the cultural shift towards UV exposure is now becoming apparent [4]

Melanoma check for the signs

Because melanoma is particularly serious, you should be familiar with the signs to look for. The ABCDE of melanoma can help you to detect it early.



EVOLUTION is the most important of the ABCDE warning signs.

A spot that has changed in size, shape, colour, elevation or another trait (such as itching, soreness, bleeding or crusting).

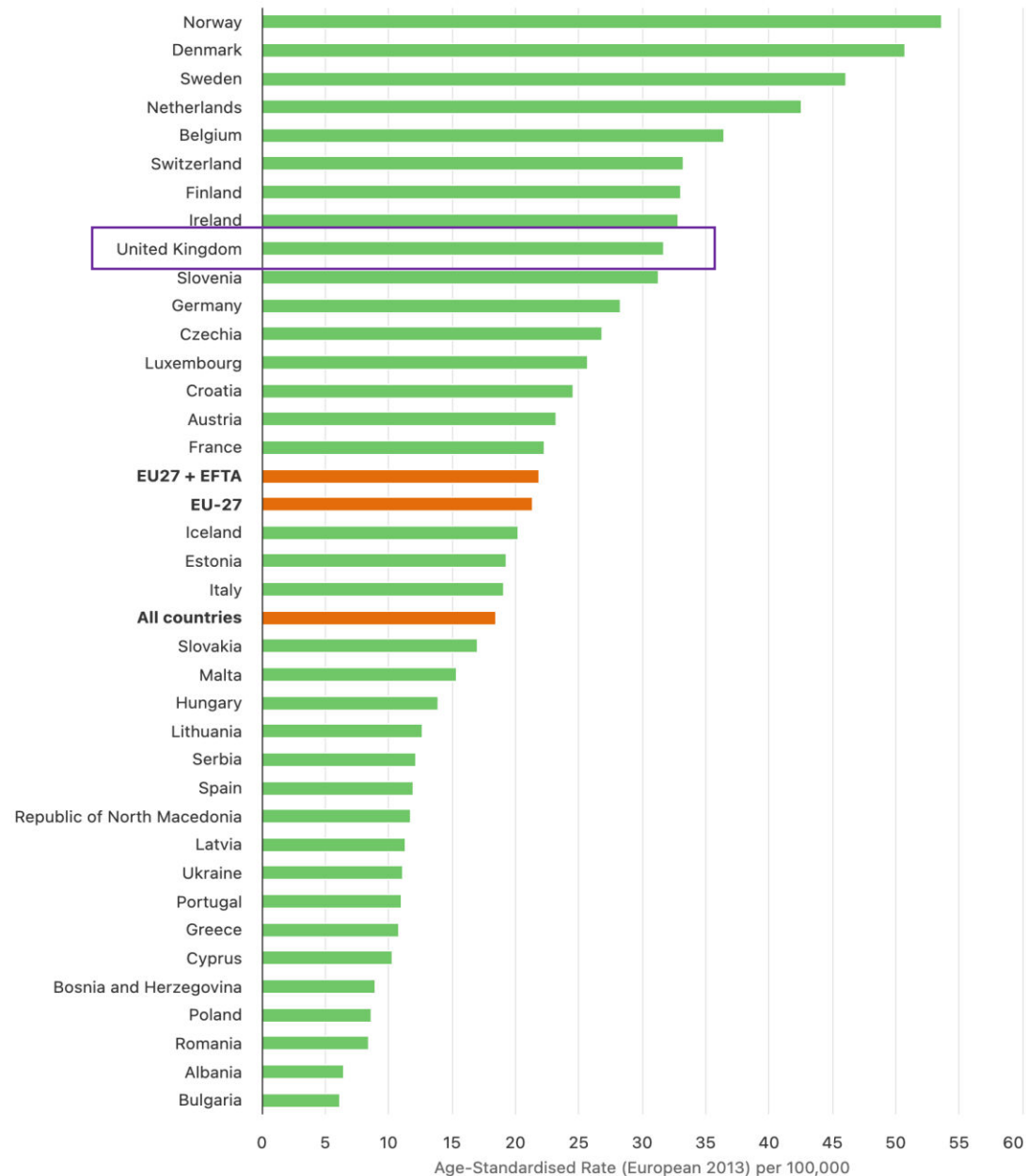
Melanoma UK encourages everyone to get regular skin checks with a healthcare professional. If you notice new or changing spots Melanoma UK advises you to seek immediate medical advice.

Skin Cancer in the UK

2024 estimates

Estimated incidence/mortality by country

Incidence, All countries, Melanoma skin, Both sexes, 0 to 85+ years, 2024



Skin cancer

Melanoma skin cancer cases in UK hit record level, analysis finds

Cancer Research UK figures show number diagnosed with most serious form of skin cancer has risen above 20,000 for first time

Tobi Thomas Health and inequalities correspondent

Fri 22 May 2026 00.01 BST

Share

Prefer the Guardian on Google

Skin Cancer MDT and Patient Safety

- In 2022, 128 organisations saw 624, 253 urgent suspected skin cancer referrals, a 2.6 fold increase from 2013 [5]
- Skin Cancer MDT services are the gold-standard framework to direct collaborative, multi-disciplinary care for patients with a suspected skin cancer as part of the two week wait pathway
- Skin Cancer MDT at Sandwell and West Birmingham NHS Trust occurs weekly and comprises of Dermatologists, Plastic Surgeons, Histopathologists, Oncologists, Dermatology Specialist Nurses and Oculoplastic Surgeons
- An electronic proforma (external/internal referrals), histopathology and photographs are discussed amongst the MDT to guide management and outcomes are formulated

Skin Cancer MDT Audit

- The aim of the audit was to assess compliance to the outcomes of Skin Cancer MDT within the Trust
- This had previously been conducted in 2021 (89%), 2020 (97%), 2019 (99%) and 2018 (98%)
- Due to disruptions caused by the COVID pandemic, recent compliance rates were not measured

Audit Methodology



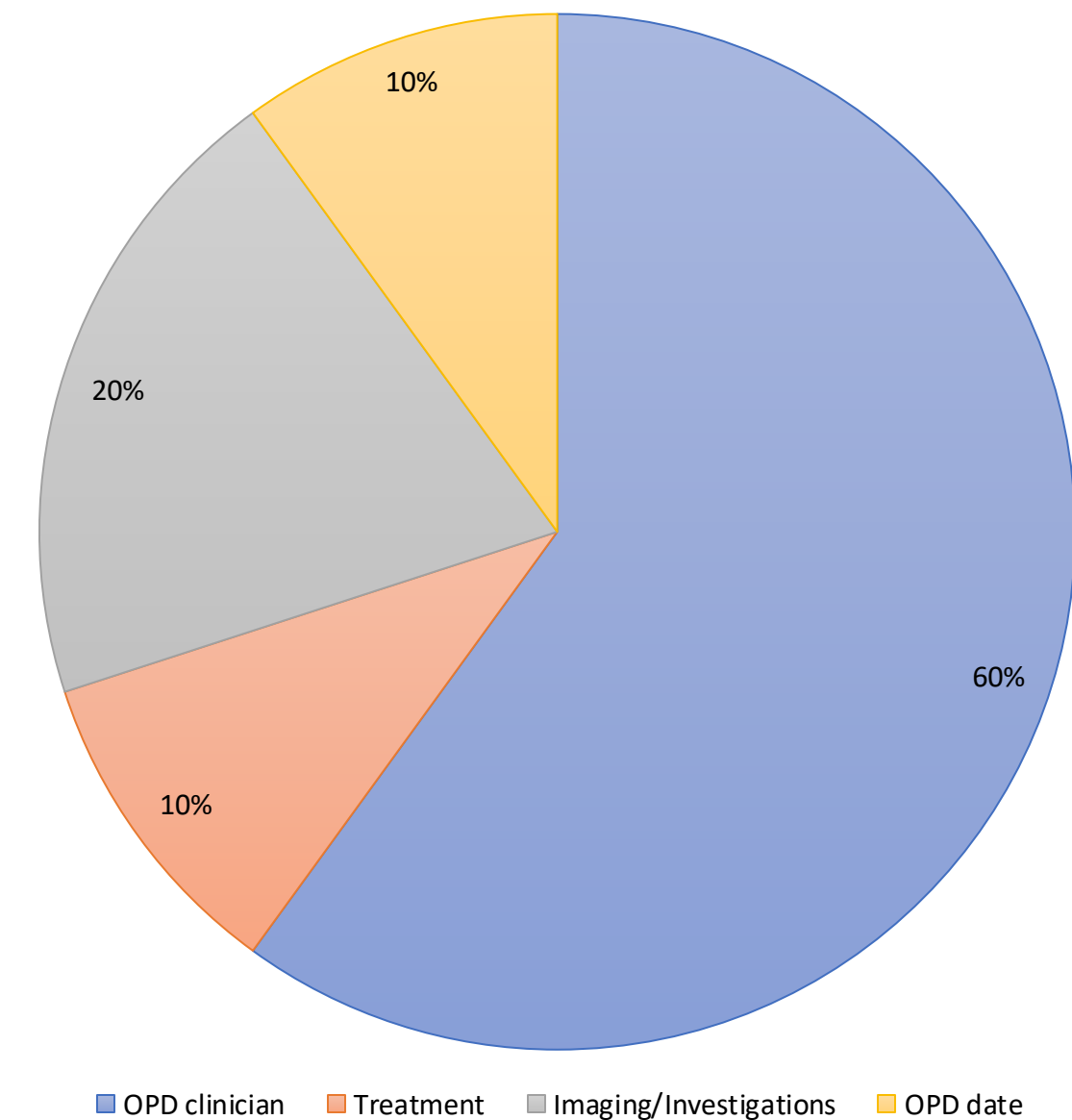
**Sandwell and
West Birmingham**
NHS Trust

- Audit Code: 51
- Two audit cycles capturing data from all MDT outcomes in July 2025 and February 2026
- Retrospective data, descriptive data analysis
- MDT outcomes compared against the Electronic Patient Record (EPR), clinic correspondence and investigation requests
- Outcome measures: achievement of MDT outcomes, deviations from the MDT outcomes, documentation of deviations and if deviations triggered a repeat MDT discussion, availability of Clinical Photographs

First Cycle Results

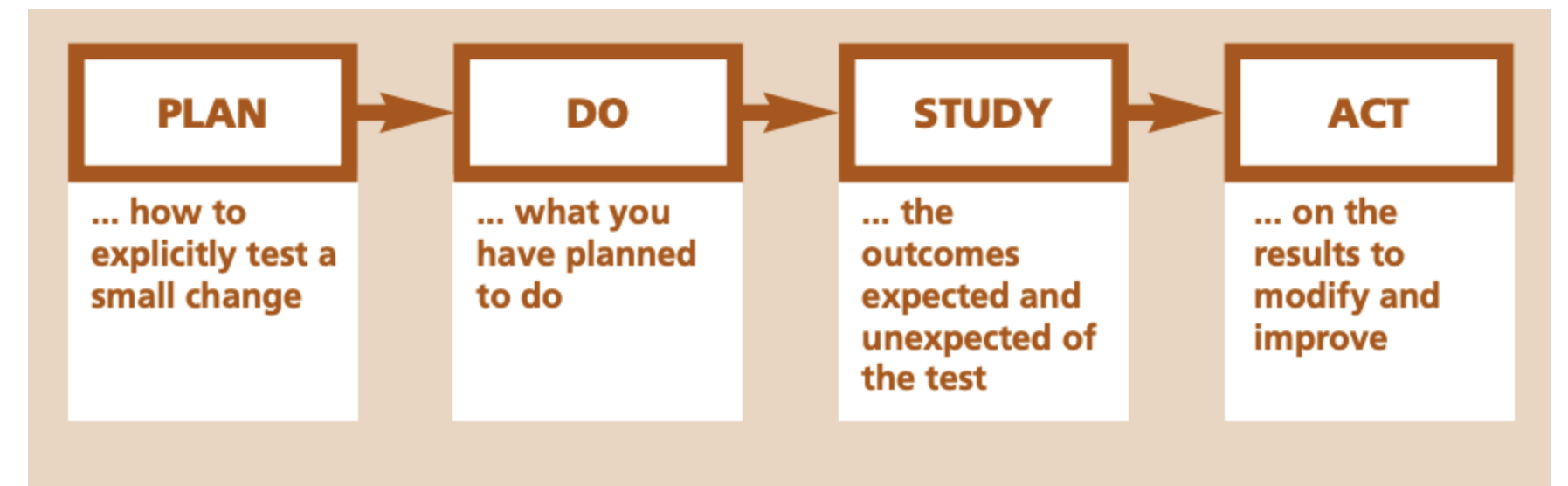
- Four MDTs (7th, 14th, 21st and 28th July 2025) included
- 39 cases discussed (1 patient rediscussed after SSMDT)
- 28/39 cases – MDT outcomes were met (74%)
- Reasons for deviations were not recorded
- 3 cases lacking clinical photographs

July 2025 MDT Outcomes



Interventions

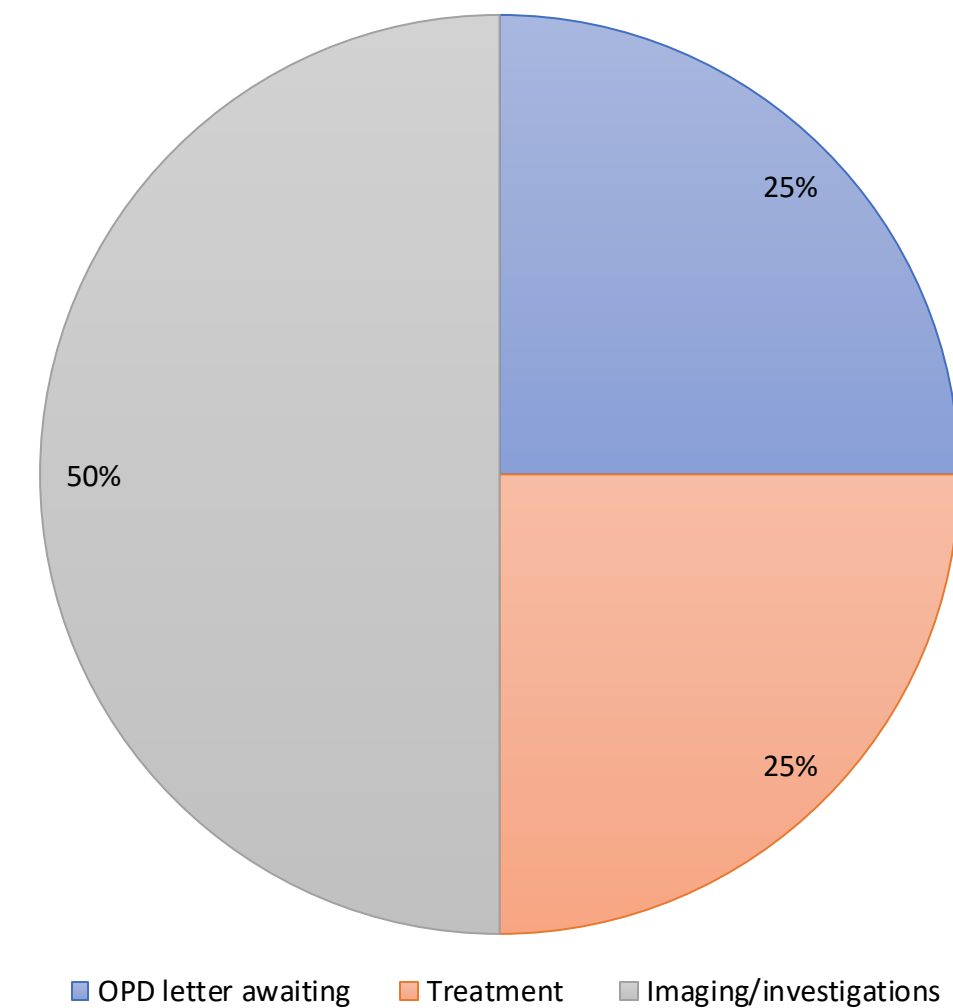
- As per the Plan-Do-Study-Act Framework [6]
- QIHD presentation of outcomes – MDT agreement on further action points, team engagement, feedback from administrative staff
- Peer-led teaching and learning resources
- Incorporation of MDT outcomes within clinic letters and follow-up appointment documentation
- Optimisation of Electronic Patient Record workflow



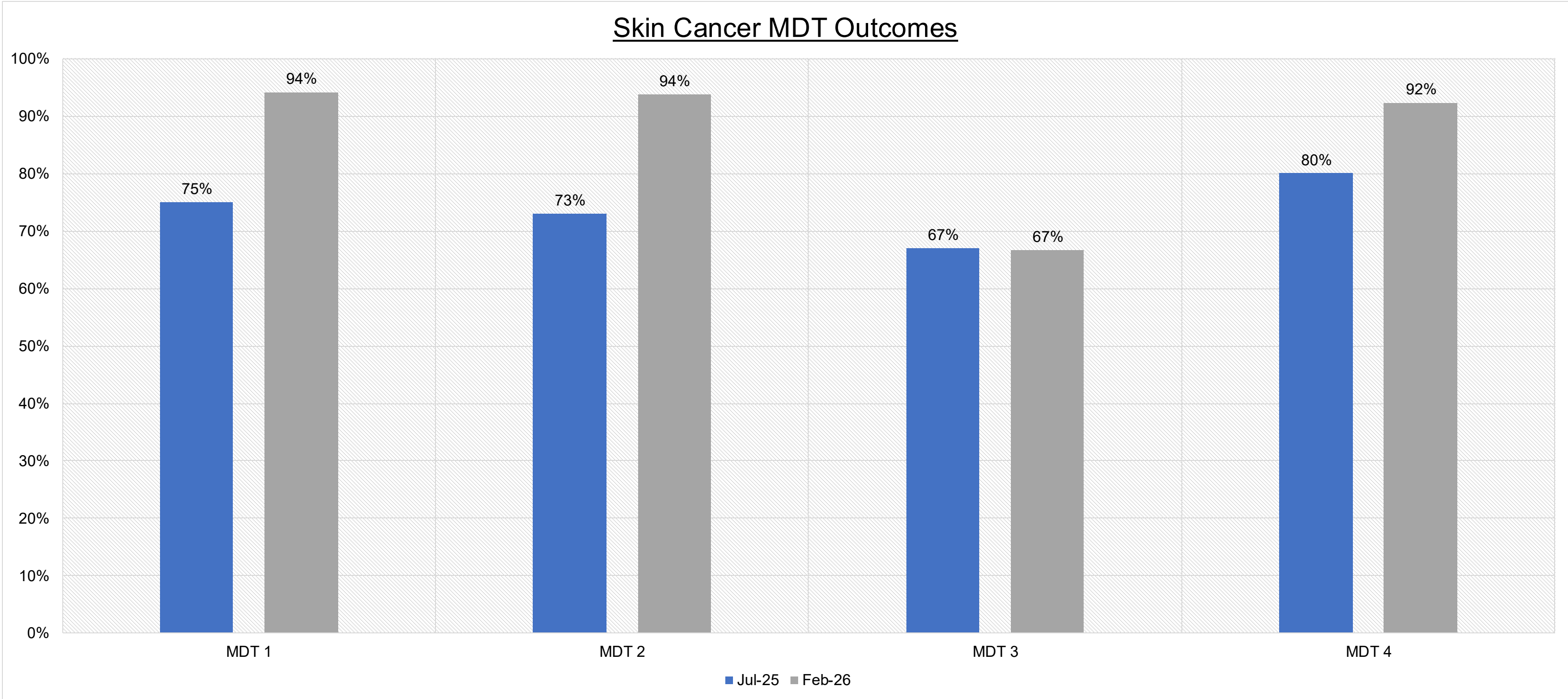
Second Cycle Results

- 4 MDTs from February 2026 included (2nd, 9th, 16th, 23rd)
- 49 cases discussed
- Compliance July 2025 - 74% (29 compliant, 10 non-compliant)
- Compliance Feb 2026 - **92%** (45 compliant, 4 non-compliant)

Feb 2026 MDT Outcomes



Second Cycle Results



Discussion

- Second loop presented in QIHD March 2026
- Auditing MDT outcomes is an essential aspect of patient care
- Closed loop audit cycles → meaningful improvement
- Multi-professional team engagement is central to audit success → promote coordination and lasting impact



References

1. Cancer Research UK. Melanoma skin cancer statistics. Available at: <https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/melanoma-skin-cancer>
2. Cancer Research UK. Melanoma skin cancer incidence trends and projections. Cancer Research UK Statistics.
3. European Cancer Information System (ECIS). Estimated incidence of melanoma by country, Europe, 2024. Available at: <https://ecis.jrc.ec.europa.eu>
4. Dessinioti C, et al. Local recurrence and survival outcomes in melanoma in situ. JAMA Dermatology. 2025;161(5):531-539.
5. British Association of Dermatologists. Service Guidance and Standards for Skin Cancer. 2024. NHS England. Streamlining Multidisciplinary Team Meetings: Guidance for Cancer Services.
6. NHS Improving Quality. Service Improvement Guide. NHS England; 2014. Available at: https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2011/06/service_improvement_guide_2014.pdf

Thank you

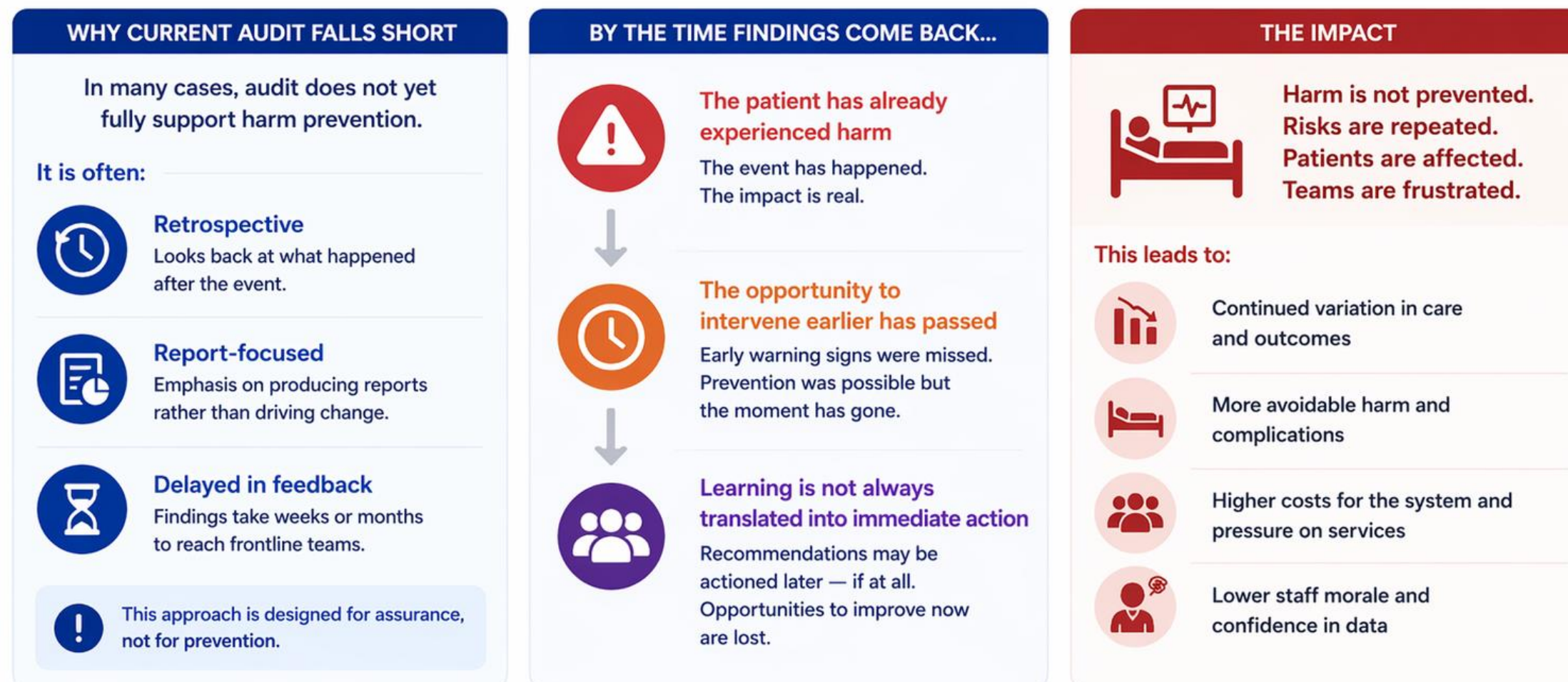
Clinical Audit and Patient Safety


Vicky Patel


Clinical Effectiveness Manager,
The Rotherham Foundation Trust

The Problem: Why Current Audit Doesn't Prevent Harm Effectively

Audit is happening — but too often it's too late to prevent avoidable harm.



 **The issue is not whether we are auditing — the issue is whether we are using audit in a way that actively prevents harm.**

 Audit should be a real-time tool for **learning, acting and improving** — not just measuring what has already happened.

Shaping the Future Together: Innovation and Transformation

Reframing Audit: From Assurance to Prevention

To prevent avoidable harm, we need to reposition clinical audit.



FROM: ASSURANCE



A retrospective assurance process

- ✗ Looks back at what has already happened
- ✗ Reports take time
- ✗ Too late to prevent harm
- ✗ Limited impact on real-time care



TO: PREVENTION



A real-time safety and improvement tool

- ✓ Provides timely insights
- ✓ Supports immediate action
- ✓ Prevents harm before it occurs
- ✓ Drives continuous improvement

KEY MESSAGE

“ Audit should not just tell us what went wrong — it should help us stop it happening again in real time. ”



THAT MEANS USING AUDIT TO...

 <p>Identify deterioration earlier</p> <p>Spot risks and early warning signs before patients get worse.</p>	 <p>Detect variation in care</p> <p>Understand where practice differs and why it matters.</p>	 <p>Highlight missed opportunities for intervention</p> <p>Find gaps where earlier action could have prevented harm.</p>	 <p>Provide rapid feedback to teams</p> <p>Share insights quickly so teams can act and improve now.</p>
---	---	--	---

CREATING IMPACT

 <p>Fewer incidents of avoidable harm</p>	 <p>Safer care for patients</p>	 <p>Empowered frontline teams</p>	 <p>Continuous learning and improvement</p>	 <p>Better outcomes, experience and value for the NHS</p>
--	--	--	--	--

Shaping the Future Together: Innovation and Transformation

What This Looks Like in Practice

Five practical ways clinical audit prevents avoidable harm



1 Focus on early warning signs



Audit:

- Deterioration (e.g. NEWS2 escalation)
- Delays in review
- Missed triggers

This allows us to identify where patients are not being escalated or reviewed in time – a key driver of avoidable harm.

2 Audit missed opportunities for prevention



Not just:

- “Was care delivered correctly?”

But:

- “Could this deterioration have been prevented?”

Examples:

- Sepsis recognition delays
- Failure to initiate preventative measures
- Missed risk factors (frailty, falls, infection)

Look beyond the outcome to identify opportunities to prevent harm earlier.

3 Look across the whole pathway



Not just within:

- A ward
- A department

But across:

- Admission → Treatment → Discharge → Community

Many harms occur at transitions – poor handover, delayed follow-up, incomplete referral.

4 Use real-time / rapid-cycle audit



Short-cycle audits:

- Weekly
- Fortnightly

Immediate feedback to teams

This is where impact happens – when teams can act immediately, not months later.

5 Use digital data intelligently



Use:

- EPR data
- Timestamped events
- Automated dashboards

This reduces burden and enables real-time visibility of risk.



Effective clinical audit prevents harm before it happens.



Earlier detection of risk



Timely intervention and escalation



Safer care for patients



Better outcomes and experience



More efficient use of resources

Audit is not just about reviewing the past – it’s about improving the future.

Shaping the Future Together: Innovation and Transformation

ALIGNMENT TO THE 10 YEAR HEALTH PLAN

Clinical audit at the heart of the future NHS



Better data.
Better decisions.
Better care.



This approach directly supports the three shifts:

Using clinical audit to improve outcomes, tackle inequalities and build a sustainable NHS.

1

SICKNESS → PREVENTION

From reacting to anticipating



Audit should focus on:

- Identifying risk earlier
- Acting before deterioration happens



Impact

Earlier intervention, reduced complications, safer care.

2

HOSPITAL → COMMUNITY

From hospital episodes to whole pathways



Audit should focus on:

- Auditing pathways beyond discharge
- Preventing readmissions and harm after hospital



Impact

Better continuity of care, fewer readmissions, less harm after discharge.

3

ANALOGUE → DIGITAL

From delayed data to real-time insight



Audit should focus on using digital data for:

- Real-time insight
- Faster escalation
- Better decision-making



Impact

Faster decisions, improved escalation, better-informed care.



KEY MESSAGE

Clinical audit becomes a tool for delivering the future model of care — not just measuring the past.



Aligned audit. Smarter insight. Earlier action. Safer care. Better outcomes.

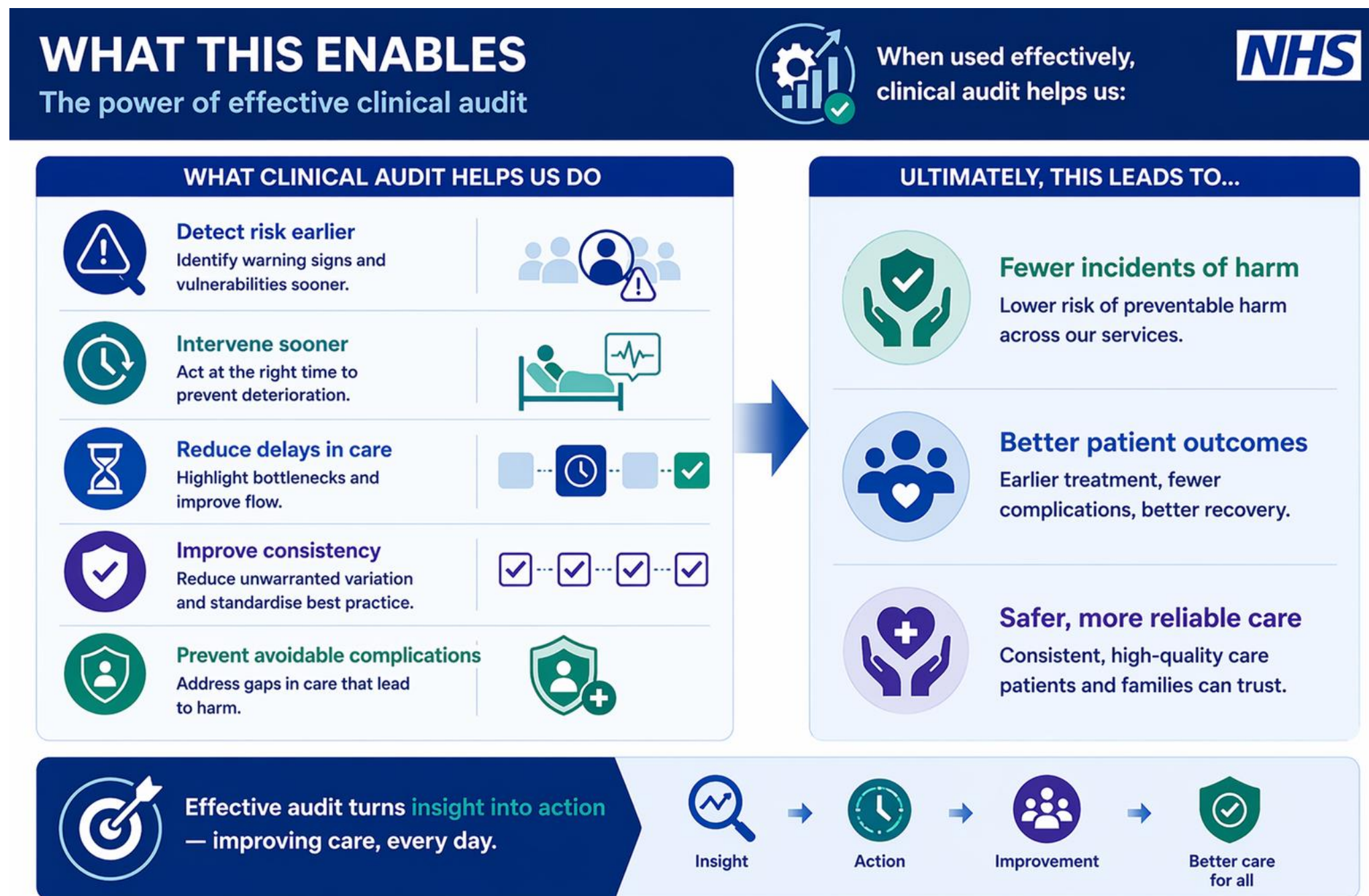
Supporting the 10 Year Health Plan through continuous learning and improvement.



HQIP

Healthcare Quality Improvement Partnership

Shaping the Future Together: Innovation and Transformation



Shaping the Future Together: Innovation and Transformation

Using Clinical Audit Differently to Prevent Avoidable Harm


Audit is more than looking back — it's how we protect patients today and improve care tomorrow.

TO TRULY PREVENT AVOIDABLE HARM, WE MUST USE AUDIT DIFFERENTLY

We must make it:

- Faster**
Deliver real-time or rapid insights so teams can act now.
- More relevant**
Focus on the risks and issues that matter most to patients and frontline teams.
- Embedded into care**
Built into everyday workflows, meetings and decision-making at the point of care.
- Focused on prevention, not just compliance**
Identify risks early, act proactively and stop harm before it happens.

PUTTING AUDIT AT THE HEART OF SAFE, PEOPLE-CENTRED CARE



IDENTIFY RISK
Spot problems and variation early

PREVENT HARM
Act early to reduce risk and avoid complications

IMPROVE CARE
Use insight to drive continuous improvement and better outcomes


EMPOWER TEAMS
Give teams the information they need, when they need it

PATIENTS AT THE CENTRE
Safe, effective and compassionate care

Continuous learning. Better decisions. Better care.

AUDIT AT THE HEART OF SERVICE DELIVERY

Clinical audit should not sit at the edge of service delivery — it should sit at the heart of how we identify risk, prevent harm, and improve care every day.



Clinical teams






Patients & families


Data & insight

Community partners

THE BOTTOM LINE

When used well, clinical audit doesn't just measure safety — it actively creates it.

-  Fewer incidents of harm
-  Better patient outcomes
-  Safer, more reliable care
-  More efficient use of resources
-  A stronger, learning NHS

 Smarter audit. Faster insight. Safer patients. Better care.

Q+A

Dr Karisma Sharma

Dr Sonika Nayyar

Vicky Patel

Upcoming Clinical Audit Awareness Week Webinars

Daily themed webinars:

Friday 26 June: Data-Informed Improvement

- Webinars at 10am-12pm and 1-3pm



Find out more and register here
- or scan the QR code:

www.hqip.org.uk/caaw26

Excellence in Clinical Audit Awards announcement:

- During Friday's 1-3pm webinar: Evidence in Practice Award

Find lots more on this topic on HQIP's website:

www.hqip.org.uk/impact-of-data/saving-and-improving-lives



THANK YOU!



Please share your feedback:

Go to www.hqip.org.uk/caaw26-feedback

Or scan the QR code

Keep up to date:

- Sign up to HQIP's mailing list: www.hqip.org.uk/subscribe-form/
- Follow us on social media & use the hashtag #CAAW26

