

Excellence in Clinical Audit Awards 2026 Announcement: Innovation Winners

Wednesday 24 June 2026, 12.45-1.30pm

THIS EVENT STARTS AT 12.45pm



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

Excellence in Clinical Audit Awards 2026 Announcement: Innovation Winners

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

Today's agenda:

- **Welcome and Award Announcements**
Caroline Rogers, Associate Director, Healthcare Quality Improvement Partnership
- **Winning Project Presentation**
- **Clinical Audit and Innovation**
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*

Innovation 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

Innovation Award 2026, Runner-Up

End of Life Care (EOLC) Champions, Whipps Cross University Hospital, Barts Health NHS Trust

Transforming End of Life Care: A Champion-Led Quality Improvement Approach



#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

Innovation Award 2026, Winner

**Data Science and Infection Prevention and Control Team,
Newcastle upon Tyne Hospitals NHS Foundation Trust**

Reproducible Analytical Pipeline for Rapid, Sustained and Statistically-Significant Improvement in MRSA Admission Screening Compliance



Innovation Winner:

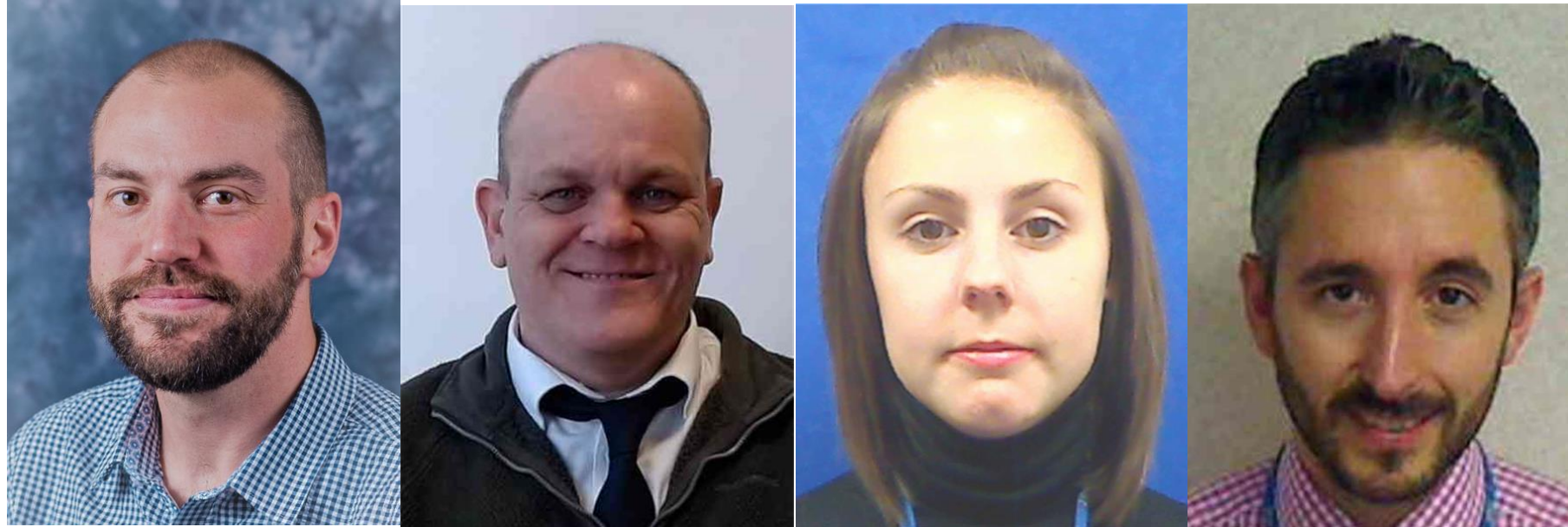
**Daniel Weiand, on behalf of the Data Science and Infection
Prevention and Control Team, Newcastle upon Tyne Hospitals
NHS Foundation Trust**

From Data to Action: Reproducible Analytical Pipeline (RAP) for Rapid, Sustained and Statistically-Significant Improvement in MRSA Admission Screening Compliance.



Meet the Team

Daniel Weiland; Paul Bradley; Caroline Cullerton; Geoff Dines;

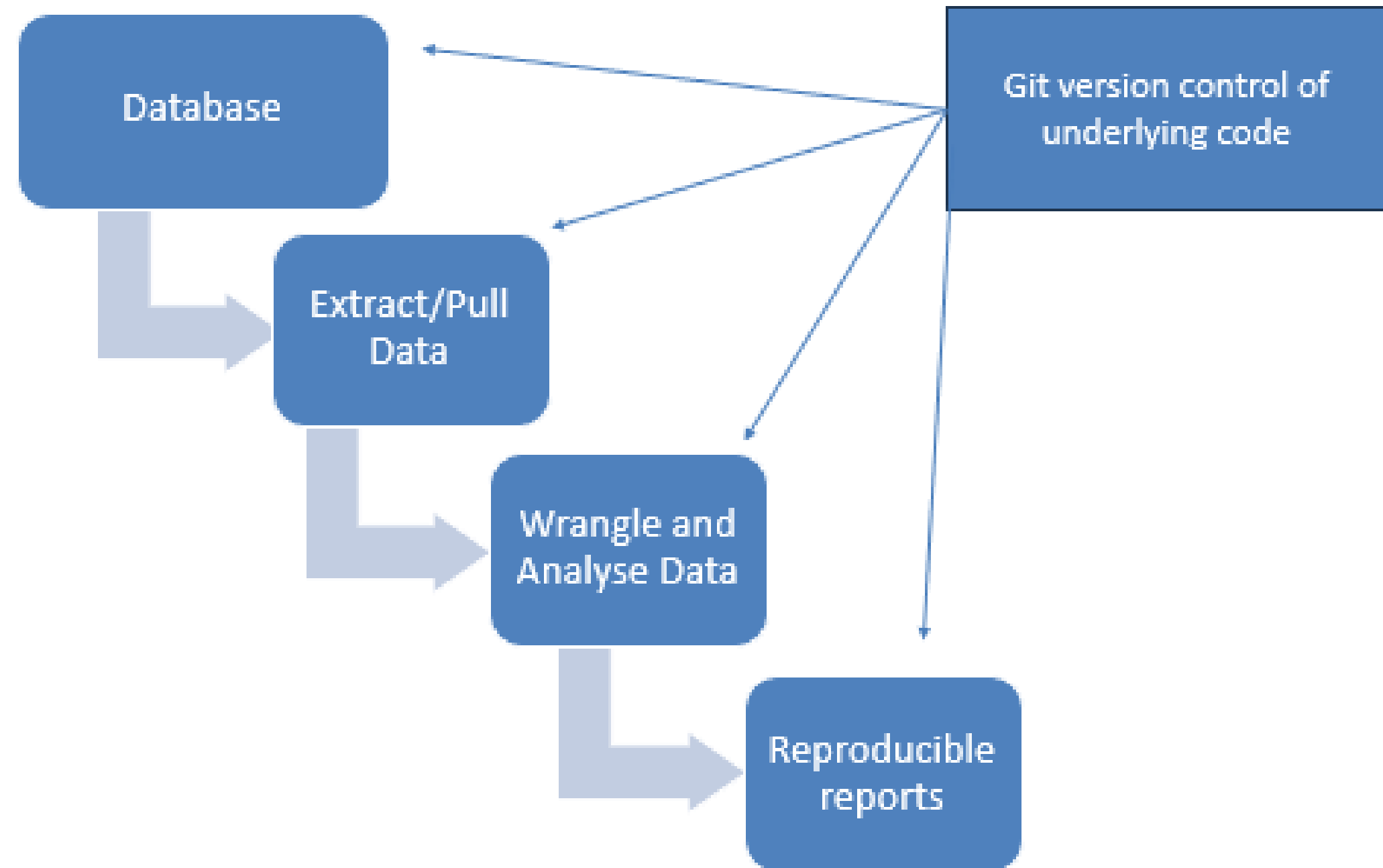


Joanne Field; Peta Le Roux; Jamie Lupton; Julie Samuel; Chris Plummer



What is a RAP?

A Reproducible Analytical Pipeline (RAP) comprises a set of principles and practices that create **faster, more robust, and transparent analytical processes**



Challenge	Benefit	How RAP Solves It
Slow reporting cycles	Reduced time to insight	Automating data extraction, processing, and output eliminates manual steps.
Lack of trust in data	Enhanced trust in data	Version-controlled code ensures the pipeline is fully auditable and consistent.
Difficulty replicating findings	Improved reproducibility and transparency	Code acts as a permanent recipe for anyone to independently achieve identical outputs.
Case-finding complexities	Better resource allocation	Programmatic, rule-based filtering automatically targets specific cohorts of interest.
Subjective decision-making	Evidence-based decision-making	Repeatable analysis ensures strategic choices are based on evidence rather than assumptions.



Problem description

MRSA blood stream infection (BSI; bacteraemia):

- National frameworks mandate organisation-level reporting of cases
- Q2 25/26, NUTH was ranked
 - ... 22nd (out of 134), in segment 2 of the dashboard
 - ... 125th (out of 134) for the metric 'Number of MRSA bacteraemia cases'

Quarter	Trust Name	Domain	Metric Description	Units	Value	Median	Lower Quartile	Upper Quartile	National Rank
Q2 2025/26	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Patient safety	Number of MRSA bacteraemia cases	count	9.00	3	1	6	125
			Number of MRSA bacteraemia cases	score	3.84				



Intervention / Strategy	RAP Role	Impact of RAP
Enhanced Surveillance & Reporting	✓ Direct	Automatically processes pathology and admission data to generate timely, patient-level intelligence.
Universal Screening & Decolonisation Protocols	✓ Direct	Programmatically evaluate compliance with MRSA policy, including admission screening practices
Prudent Antimicrobial Stewardship	✓ Direct	Facilitate earlier review of antimicrobial prescriptions in MRSA-positive patients
Innovation & Technology	✓ Direct	RAP allows for automated, patient-level surveillance of key assurance measures, and rapid sharing of results
Leadership Engagement & Governance	✓ Direct	Delivers fully auditable, trustworthy, timely and immediately actionable data to key stakeholders
Staff Education & Competency	🔗 Indirect	Ward-level data allows educators to target training and intervention where it is objectively needed most
Optimised Hand Hygiene Compliance	✗ None	Physical clinical practice. RAP cannot monitor bedside compliance.
Rigorous Environmental Cleaning	✗ None	Physical clinical practice. RAP cannot clean a ward.



Problem description

At NUTH, MRSA admission screening is mandated for practically most inpatients

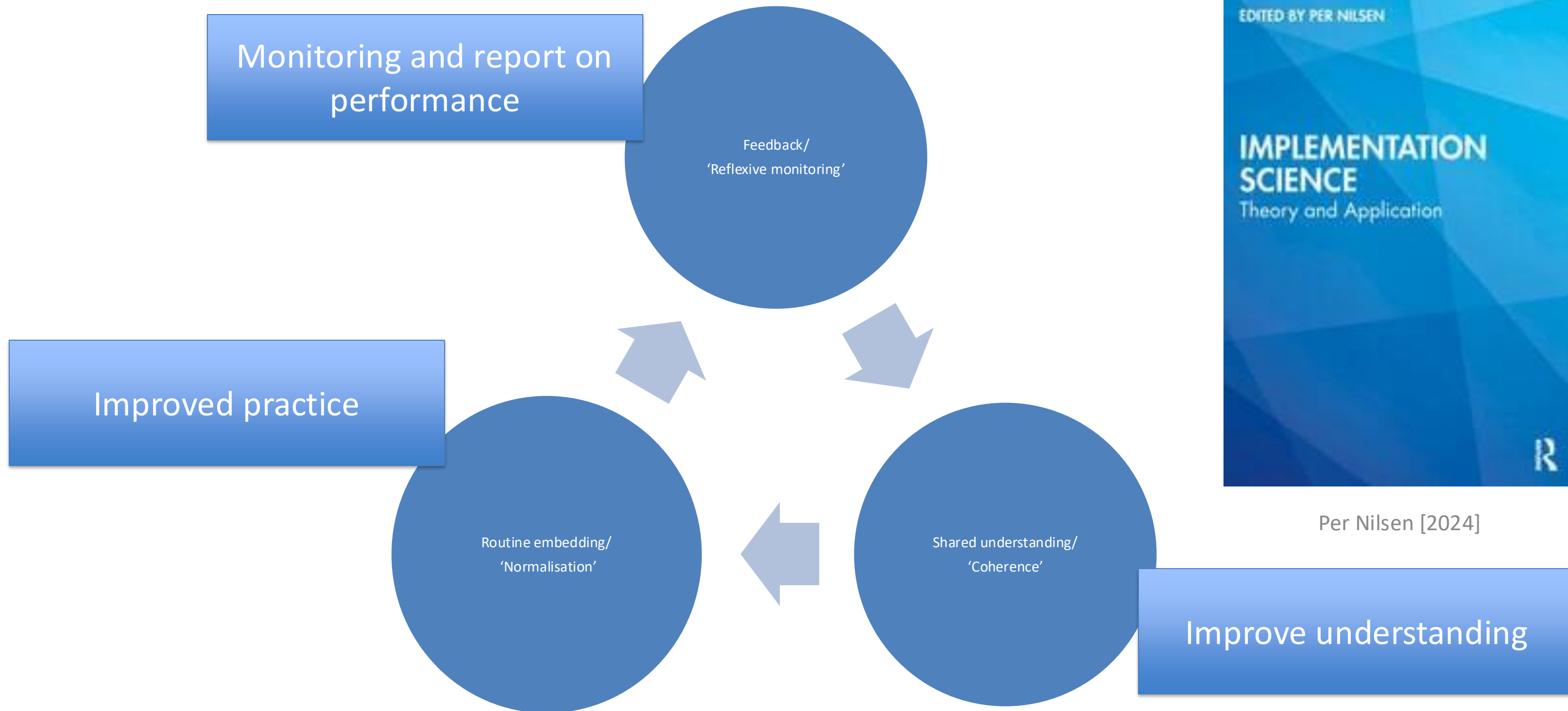
Screening must be undertaken between:

[18 weeks preceding admission] –
[admission date]

Prior to this project, MRSA admission screening compliance levels were effectively unknown at NUTH.



Normalisation Process Theory (NPT)



Per Nilsen [2024]



Aims

To develop and implement a RAP

...That triangulates data from different silos

...To prospectively evaluate, report, monitor and improve compliance with MRSA admission screening practices



Setting

Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH)

Major tertiary care NHS provider

Approximately 16,000 staff

Serving around two million patient contacts annually.

The microbiology laboratory at NUTH is fully UKAS-accredited to ISO 15189:2022 (18,19)



RAP

RAP

- using modular, re-usable, git version-controlled code

Data extraction, on a weekly basis

- from secure data warehouse (DWH), using SQL and R programming.

Data wrangling (inc. cleaning, quality-checks, and analysis)

- using R programming .

Final output: standardised HTML format report,

- generated using Quarto.

Automatically uploaded to a secure, central intranet hub

- data science intranet site

🚫 Welcome to the Data Science Intranet Site

This front page provides quick links to our latest interactive data reports. Please select a report below to access data visualisations and insights.

About this site

This site serves as a central hub for data science outputs created using [Open-source \(free\)](#) programming languages, including [Python](#) and [R programming](#).

The aim is to provide easy access to interactive, regularly updated reports that facilitate informed decision-making, promote transparency, and encourage the use of data-driven insights in everyday practice.

Only the latest version of each report will be stored on this Site. The reports published here should not be saved to create large datasets, as this goes against the [Caldicott principles](#).

⚠️ Important notice

The reports accessible from this site contain **sensitive clinical and operational data**. Please ensure you adhere to Trust policies and information governance requirements when viewing or discussing these reports. Do not distribute content outside approved channels or to unauthorised individuals.

Reports

Choose appropriate option from tabs, below.

Antimicrobial stewardship

[Laboratory metrics](#)

These reports are updated on a **weekly basis**

Last update: Tuesday 11-11-25

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[About this site](#)

[Reports](#)

[FAQs](#)

[Contact](#)

[Feedback](#)



[CPE and CPO Report](#)

- Comprehensive analysis of all significant CPE/CPO results—culture, immunoassay, and molecular tests

[Critical-Flagged, Positive Blood Cultures Report](#)

- Automated analysis of data on the last 14 days' critical-flagged, flagged blood culture results

[Critical-Flagged, Positive Blood Cultures linked with Antimicrobial Prescriptions](#)

- Links data on the last 14 days' critical-flagged, flagged blood culture results with data on practically all inpatients' antimicrobial prescriptions

[Gentamicin Prescriptions Report](#)

- Automated analysis of inpatient gentamicin prescriptions

[MRSA Positive Patients Prescribed Antimicrobials Report](#)

- Automated analysis of systemic antibiotic prescriptions for patients with a history of MRSA at NUTH

[MRSA Screening Compliance Report](#)

- [Evaluation of universal MRSA admission screening compliance](#)

[Penicillin Allergy Delabelling Report](#)

- Surveys prescribing data to identify penicillin allergy delabelling opportunities

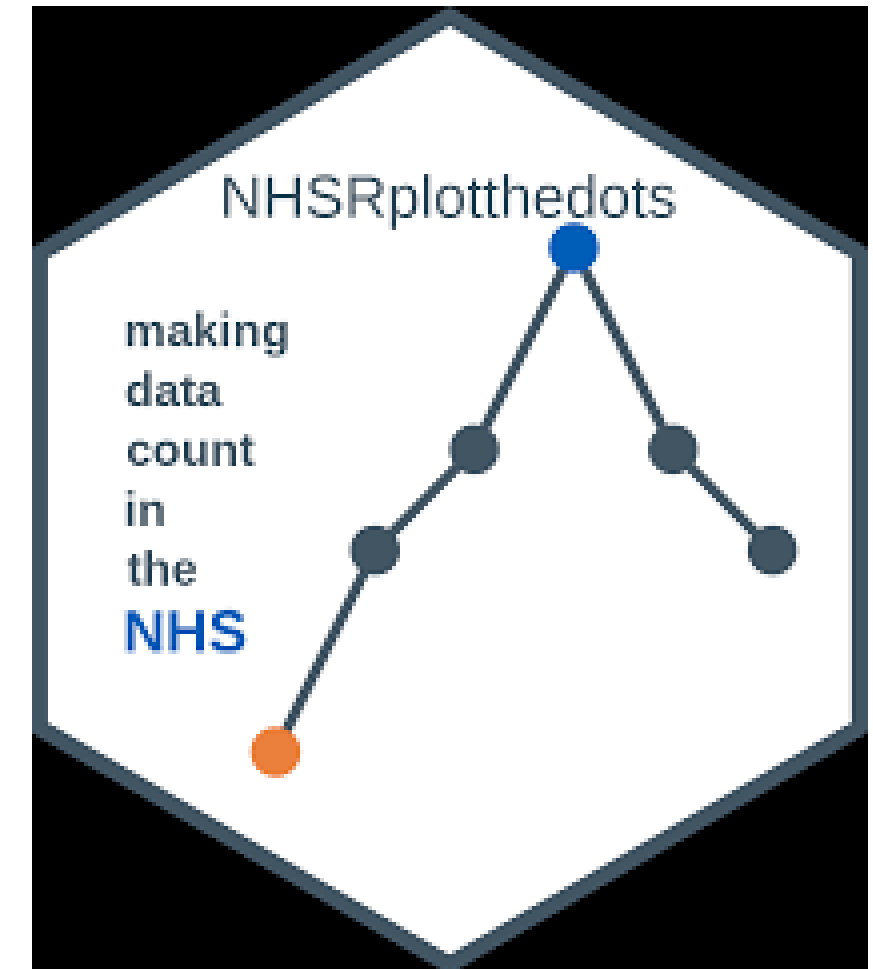


Approach to Assessing Impact

Design: Prospective weekly surveillance study

Systematic outcome measurement commenced on 07/01/2025

Time series analysis using Statistical Process Control (SPC) methods used to detect meaningful changes in compliance



Selection of participants (pragmatic approach)

Inclusion criteria:

- all current inpatients at NUTH; with
- length of stay of at least 24 hours; and
- prescribed a new inpatient medication within the previous 7 days.

Exclusion criteria:

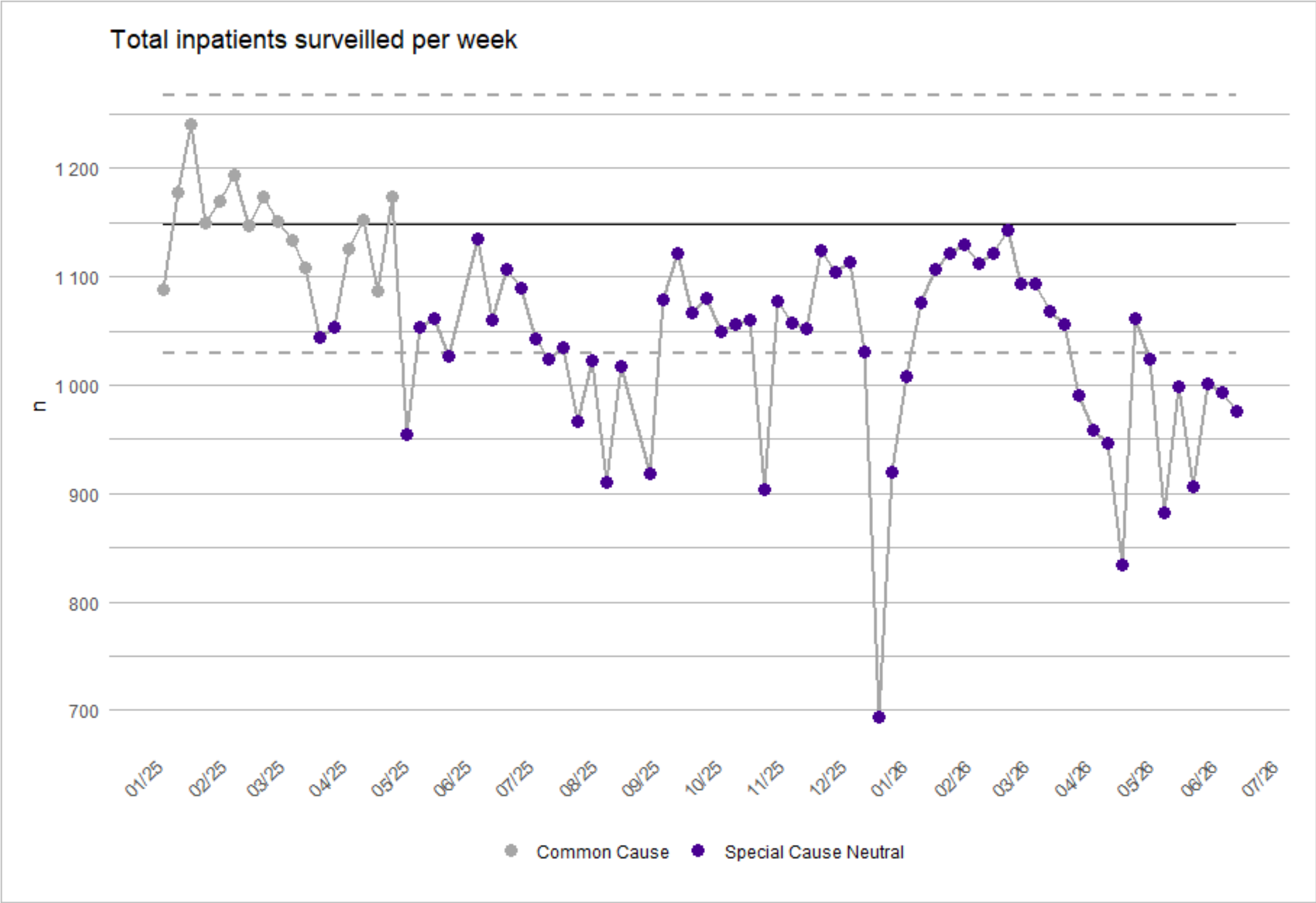
- admitted >6 weeks prior to the date of analysis; or
- exempt from MRSA admission screening as per policy.



Results

Between 07/01/2025
and 16/06/2026
(~ 1.5 years)

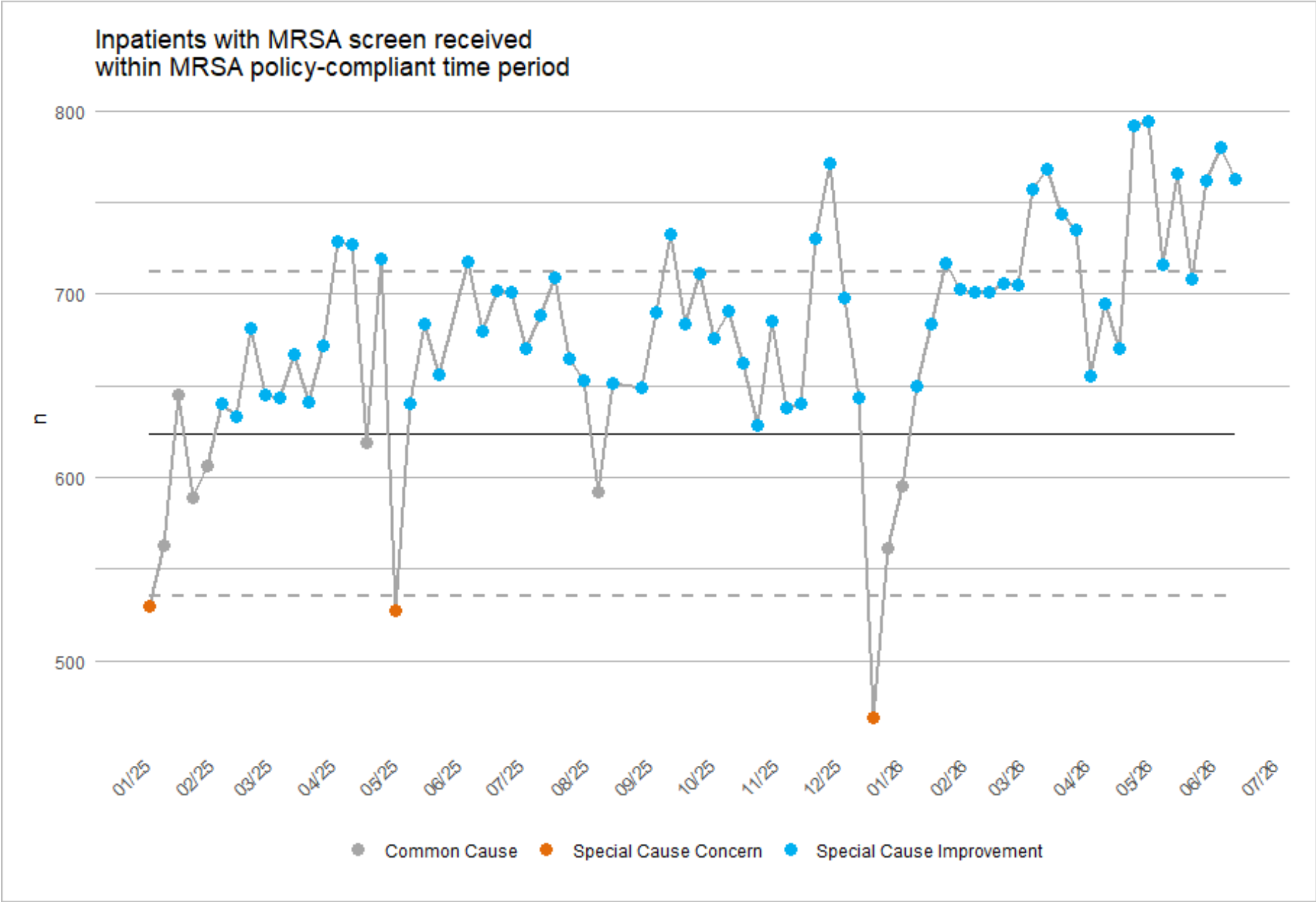
**Total inpatients
surveilled per week
(n)**



Impact of RAP on screening

Between 07/01/2025
and 16/06/2026
(~ 1.5 years)

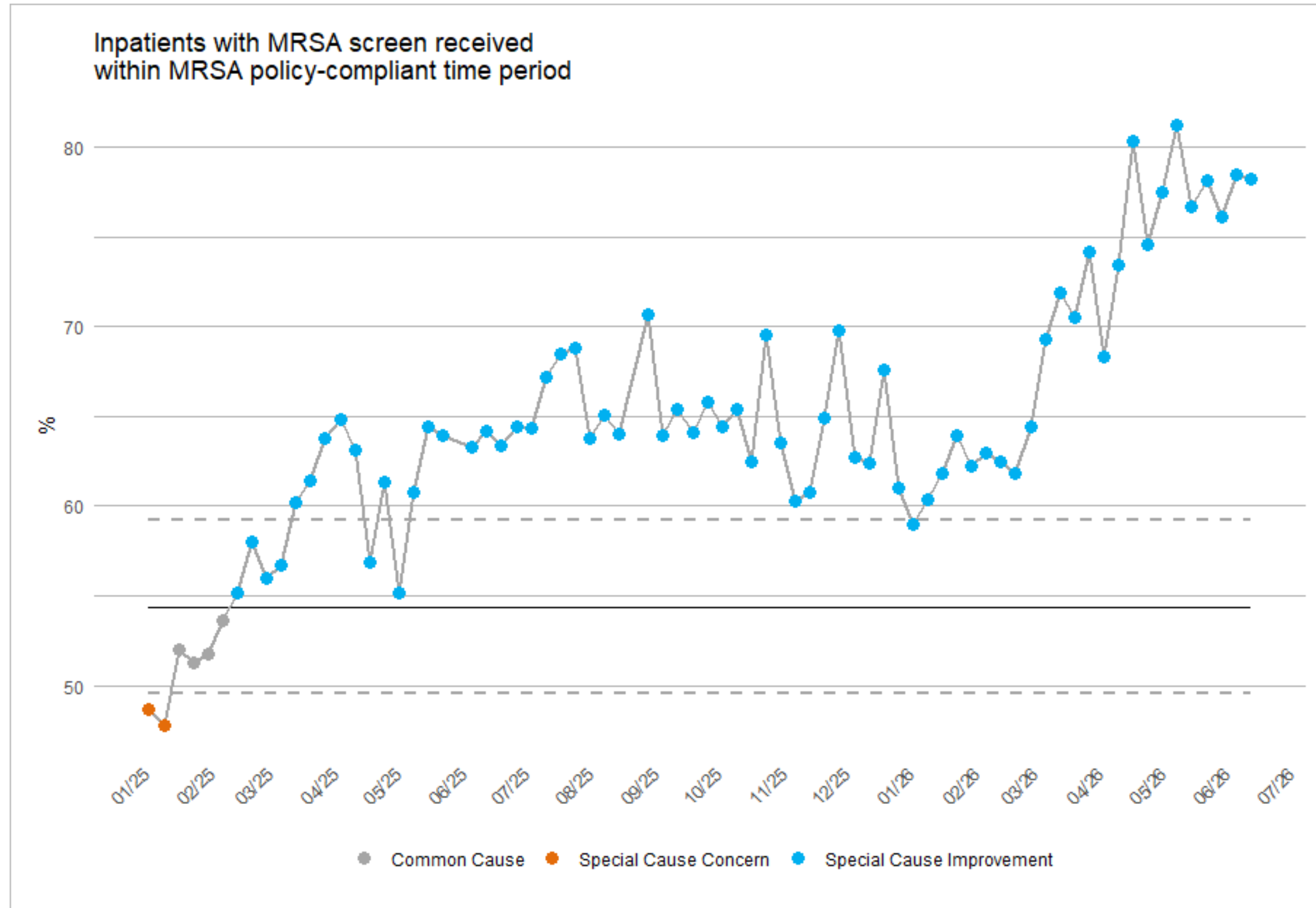
**Inpatients compliant
with MRSA admission
screening (n)**
(higher is better)



Impact of RAP on screening

Between 07/01/2025
and 16/06/2026
(~ 1.5 years)

**Compliance with
MRSA admission
screening (%)**
(higher is better)



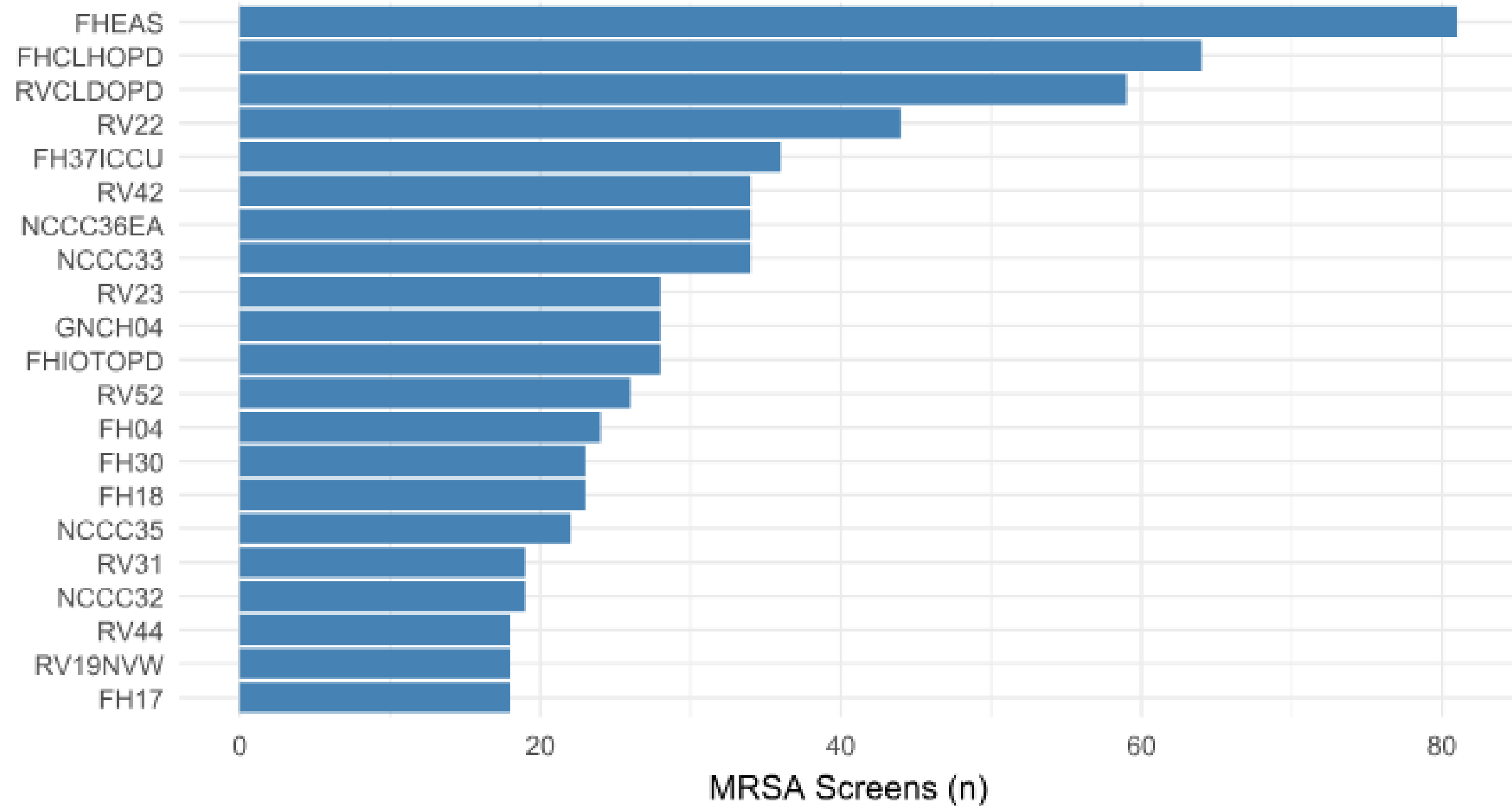
Data for the week ending 03/02/2026
Time 0

RVAS doesn't feature in the top 10 wards

*Improvements in
MRSA admission
screening compliance
driven by RVI
Assessment Suite
(RVAS) staff*

**Number of MRSA
screens received per
location (n)**

Where was MRSA Screening Undertaken for Compliant Patients?



Only the top 20 locations are shown.



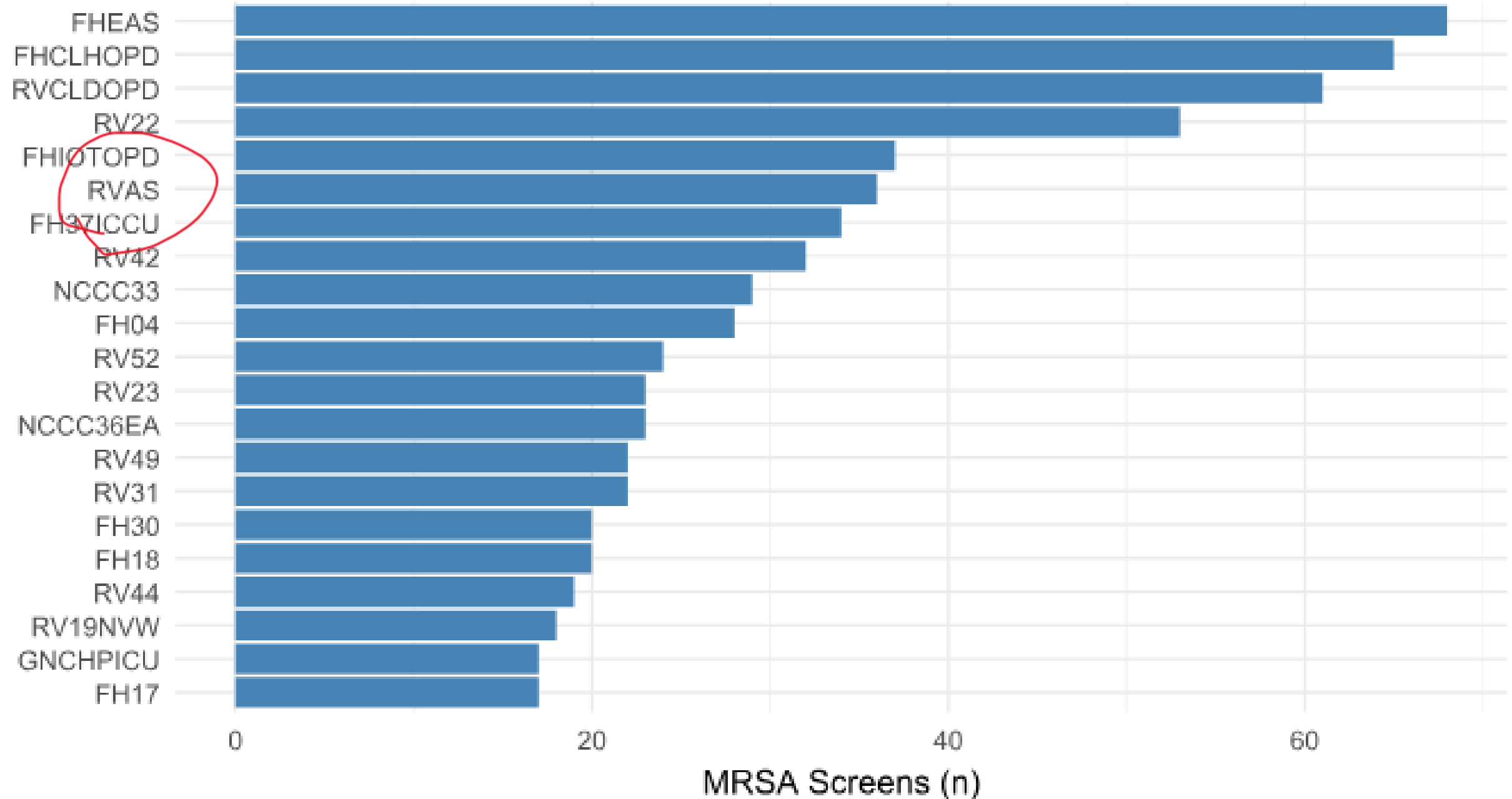
Data for the week ending 10/02/2026
Time +1 week

RVAS is 6th

*Improvements in
MRSA admission
screening compliance
driven by RVI
Assessment Suite
(RVAS) staff*

**Number of MRSA
screens received per
location (n)**

Where was MRSA Screening Undertaken for Compliant Patients?



Only the top 20 locations are shown.

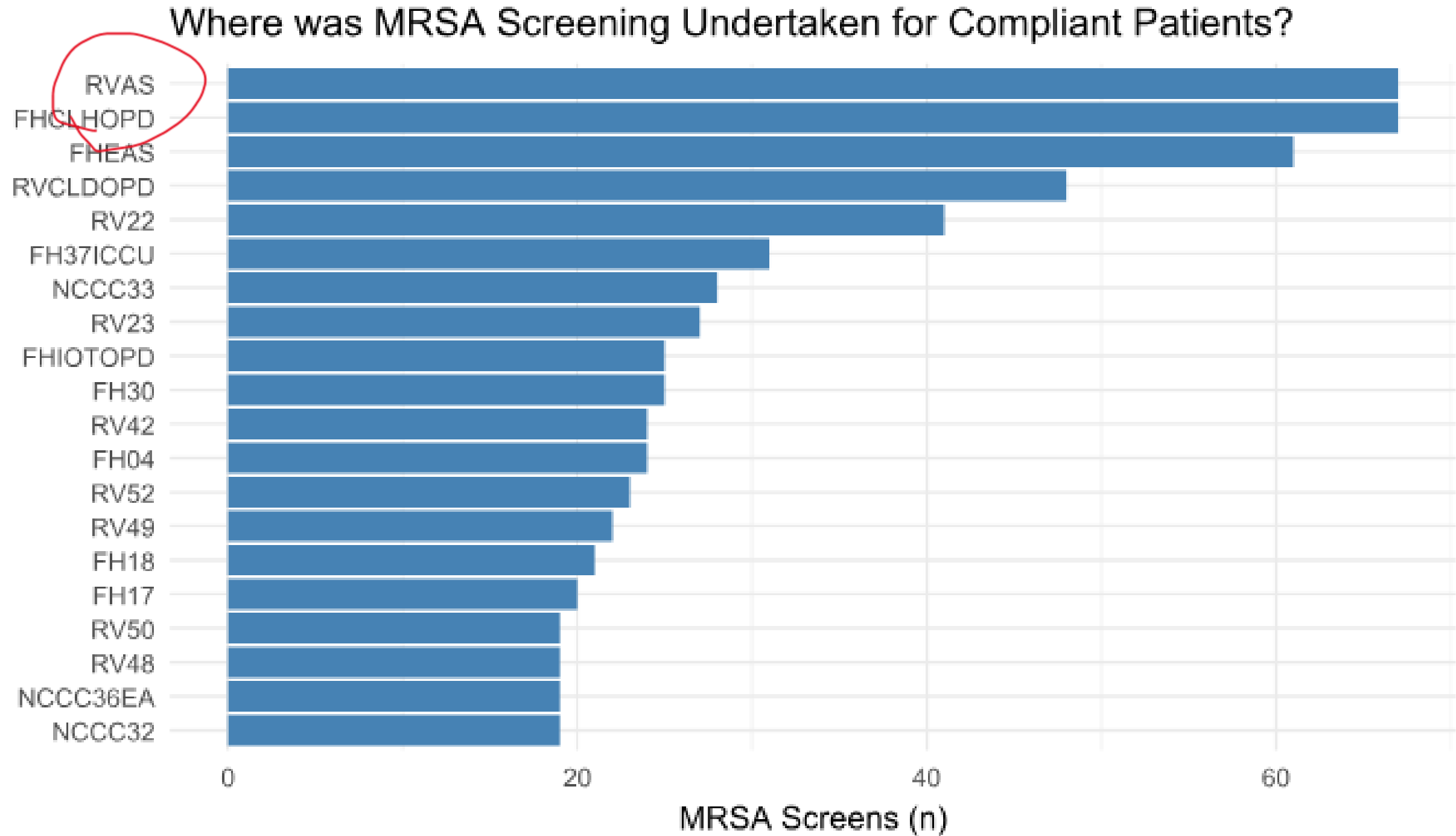


Data for the week ending 17/02/2026
Time +2 weeks

RVAS is joint-top screening location

**Improvements in
MRSA admission
screening compliance
driven by RVI
Assessment Suite
(RVAS) staff**

**Number of MRSA
screens received per
location (n)**



Only the top 20 locations are shown.

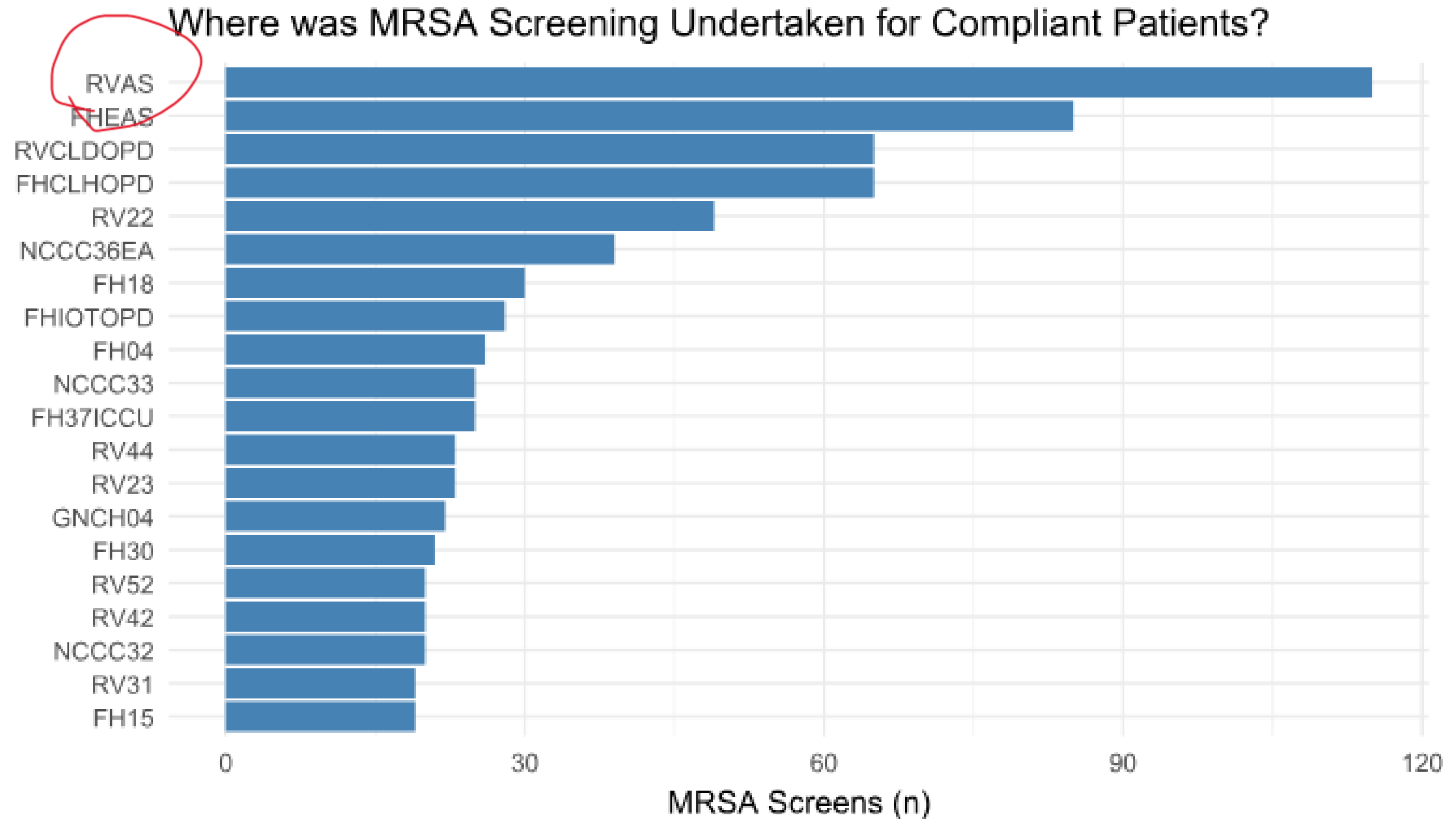


Data for the week ending 24/02/2026
Time +3 weeks

RVAS is number 1 screening location

**Improvements in
MRSA admission
screening compliance
driven by RVI
Assessment Suite
(RVAS) staff**

**Number of MRSA
screens received per
location (n)**



Only the top 20 locations are shown.

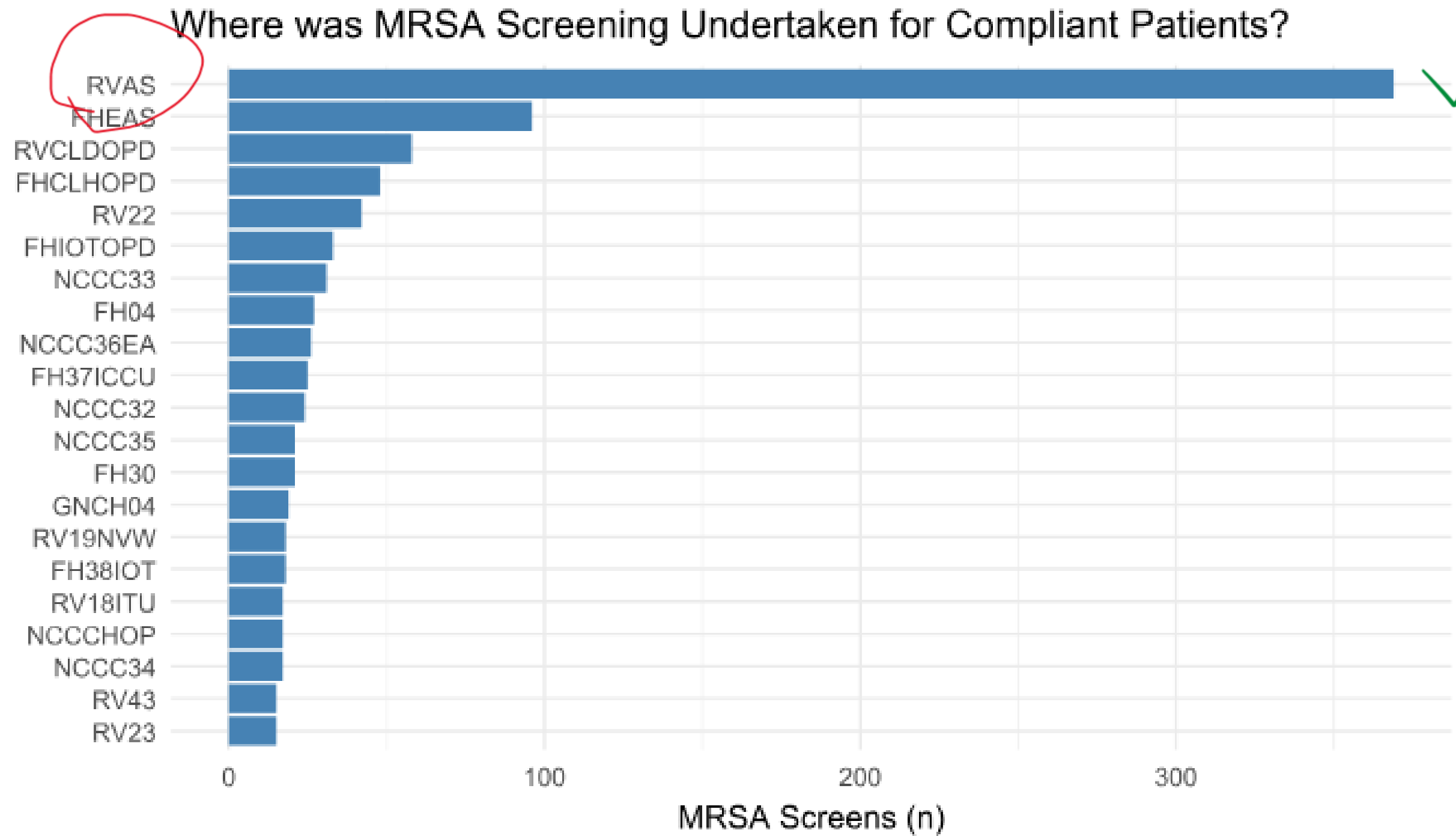


Data for the week ending 16/06/2026
Time +4 months

RVAS is now *far-and-away* the number 1 screening location

**Improvements in
MRSA admission
screening compliance
driven by RVI
Assessment Suite
(RVAS) staff**

**Number of MRSA
screens received per
location (n)**



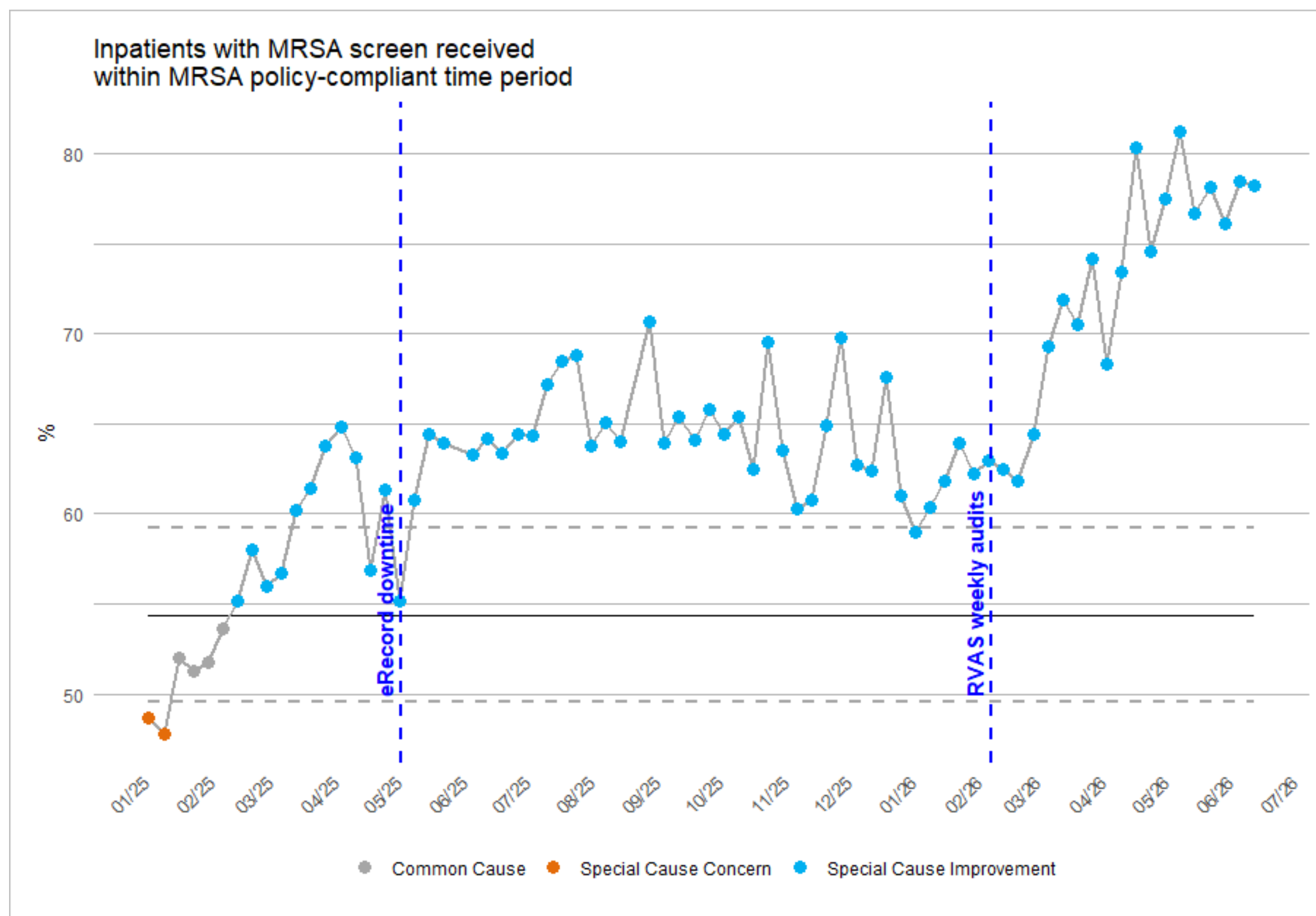
Only the top 20 locations are shown.



Impact of RAP on screening + locally-driven QI

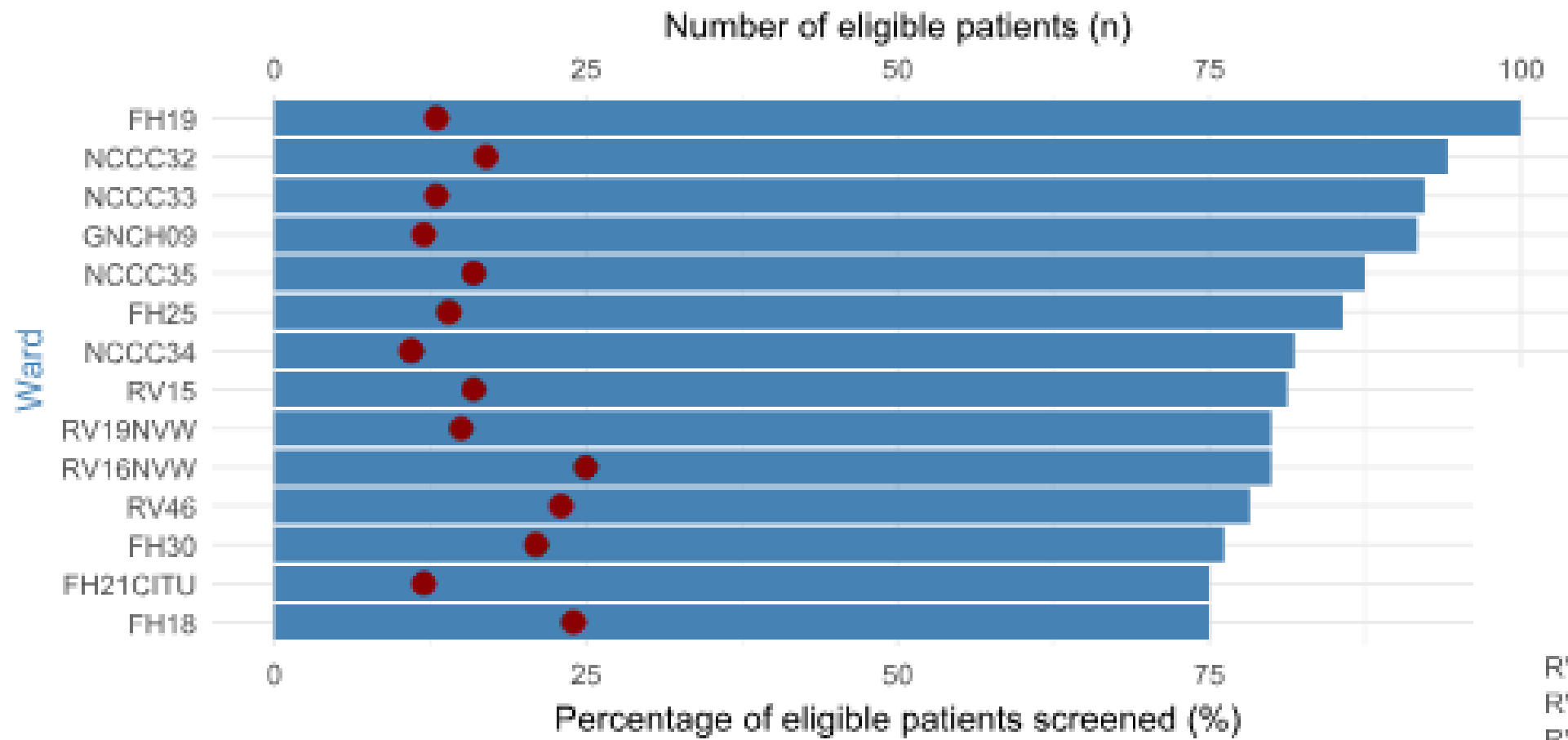
Between 07/01/2025
and 16/06/2026
(~ 1.5 years)

**Compliance with
MRSA admission
screening (%)**
(higher is better)
- annotated



**MRSA Screening Compliance by Ward:
Wards with highest compliance rate (min. 10 eligible patients)**

Bars show percentage screened, points show number of eligible patients



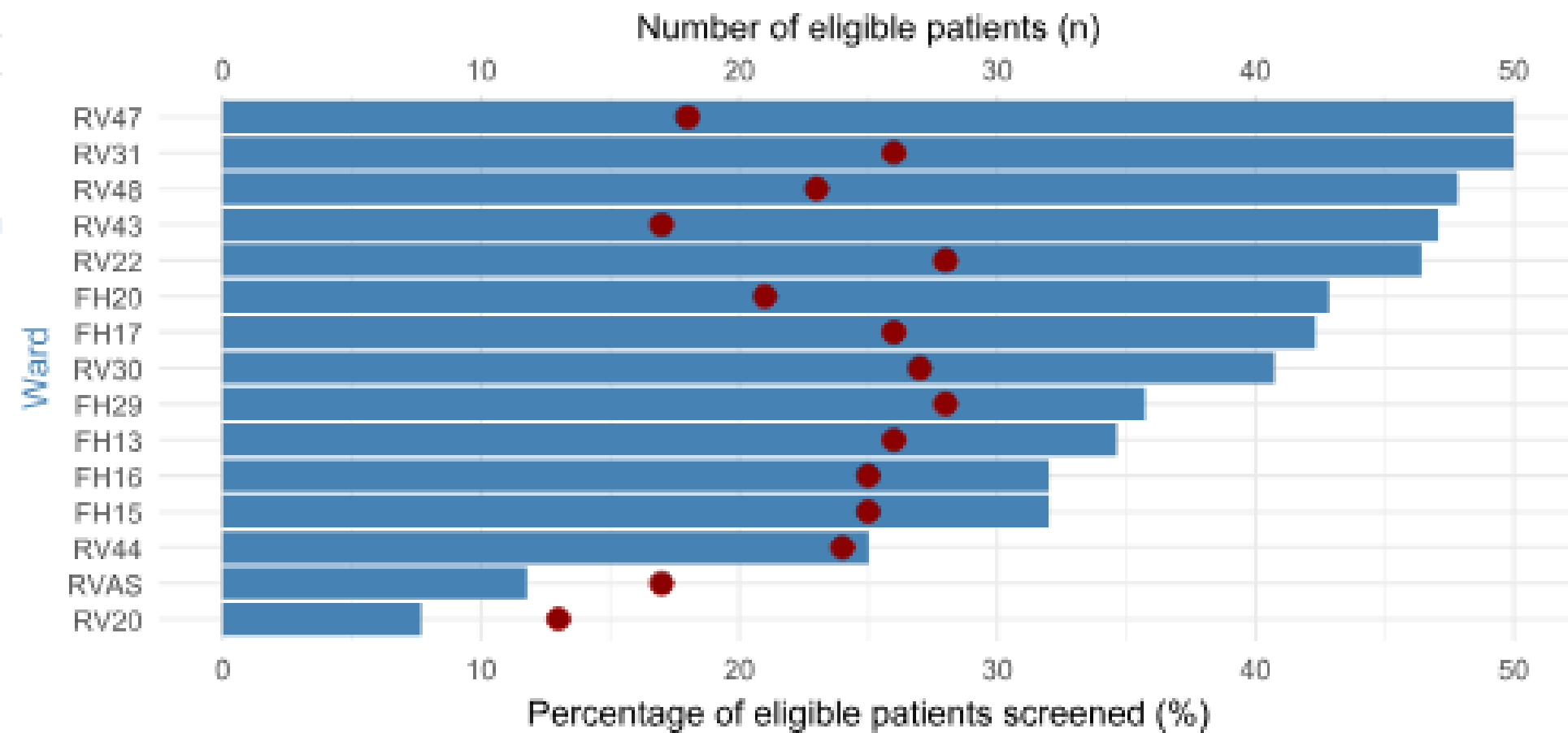
Some wards with high number of patients eligible for MRSA screening have low MRSA screening compliance

Best performers



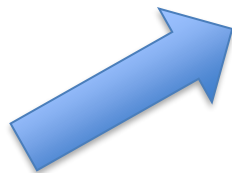
**MRSA Screening Compliance by Ward:
Wards with lowest compliance rate (min. 10 eligible patients)**

Bars show percentage screened, points show number of eligible patients



Some wards with high number of patients eligible for MRSA screening have low MRSA screening compliance

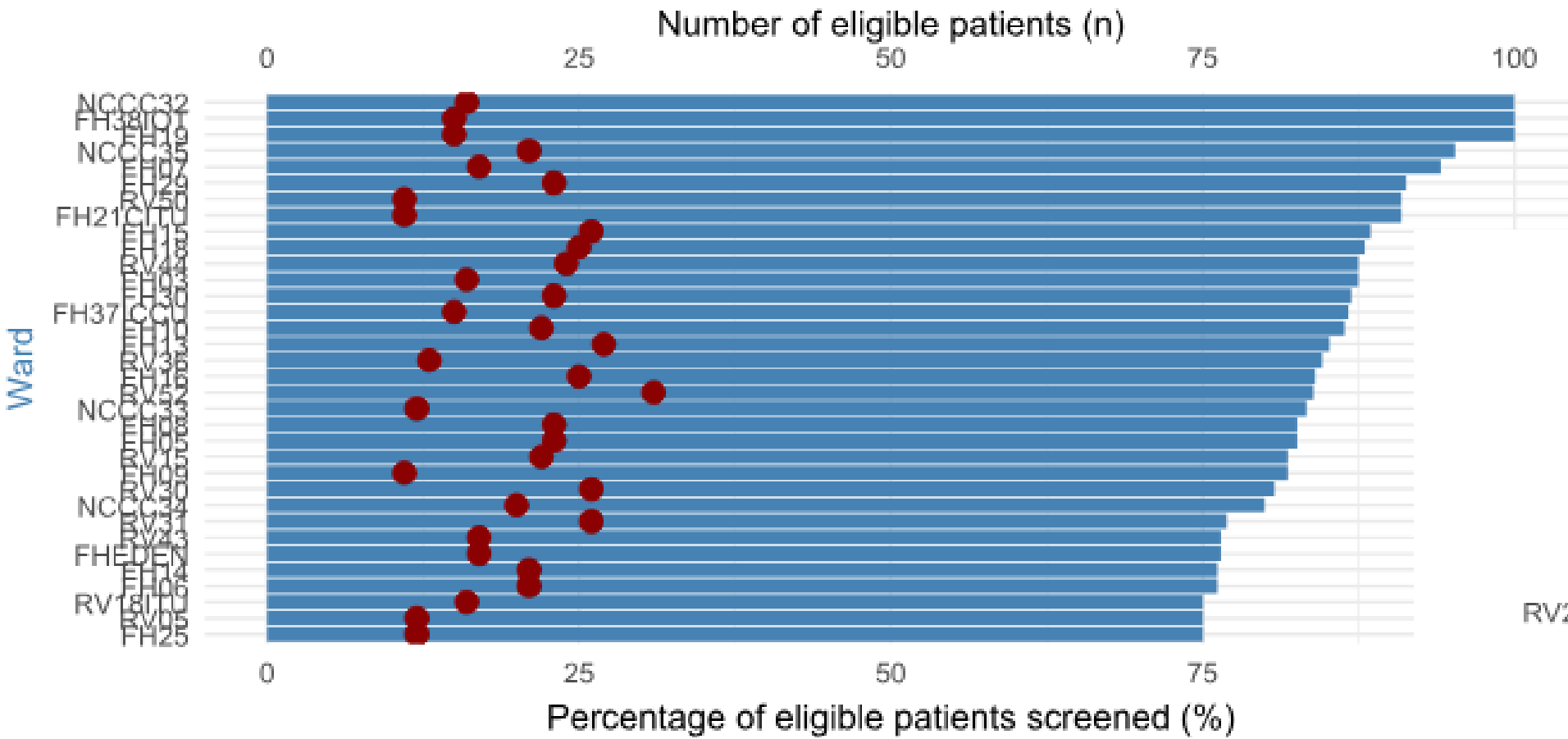
Requiring improvement



Data for the week ending Tuesday 11/11/2025

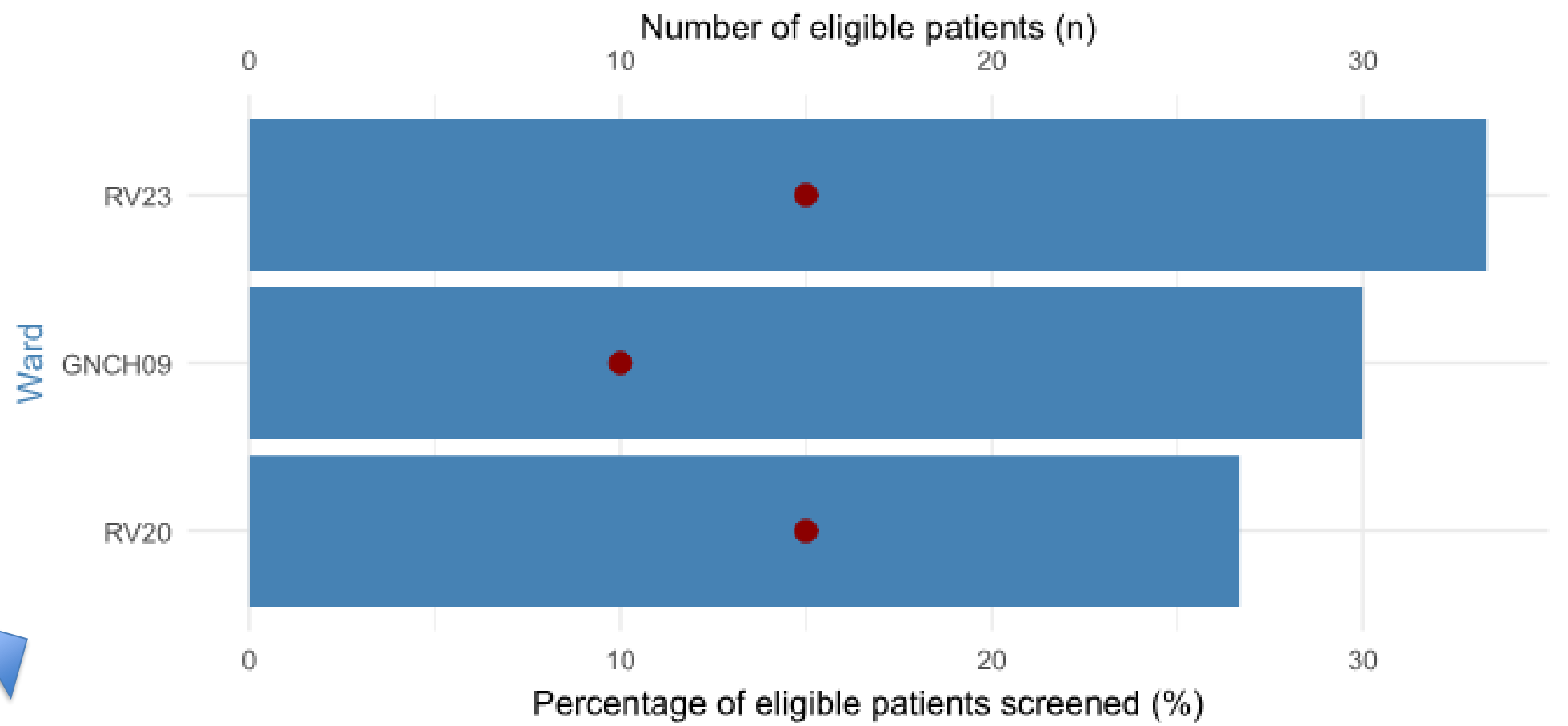


MRSA Screening Compliance by Ward:
 Wards with highest compliance rate (min. 10 eligible patients)
 Bars show percentage screened, points show number of eligible patients



Best performers

MRSA Screening Compliance by Ward:
 Wards with lowest compliance rate (min. 10 eligible patients)
 Bars show percentage screened, points show number of eligible patients



Requiring improvement

Some wards with high number of patients eligible for MRSA screening have low MRSA screening compliance

Some wards with high number of patients eligible for MRSA screening have low MRSA screening compliance

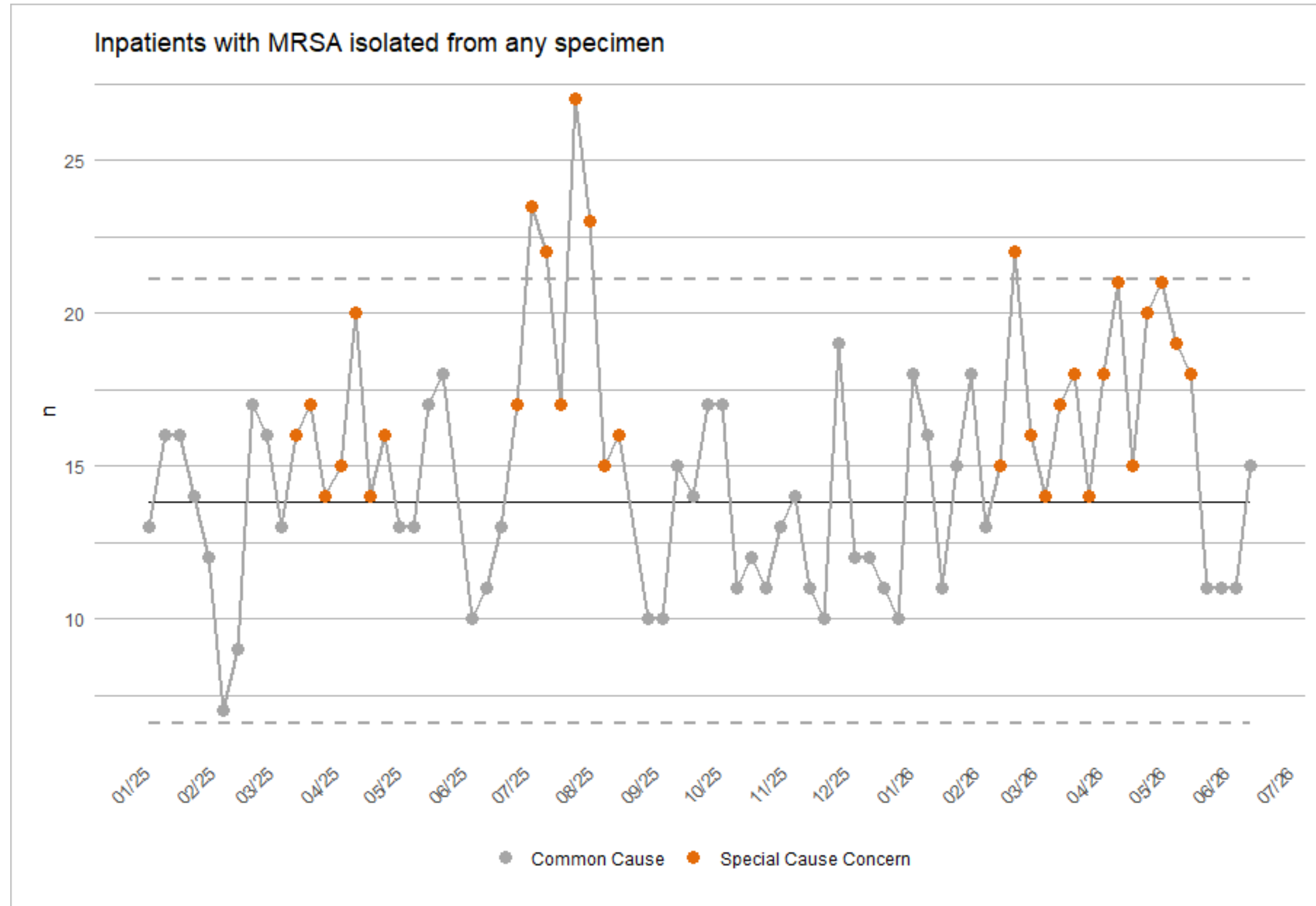
Data for the week ending Tuesday 23/06/2026



Impact of RAP on MRSA rates

Between 07/01/2025
and 16/06/2026
(~ 1.5 years)

**Inpatients with MRSA
isolated from any
specimen type
(prevalence)
(lower is better)**



RAP reliability

Between 07/01/2025 and 16/06/2026 (~ 1.5 years):

Reports were successfully published for 75 out of 77 weeks (97.4%)

- Two weeks of missed reporting:
 - 1x summer holidays data science team staffing constraints; and
 - 1x unscheduled lab information management system (LIMS) downtime

No significant modifications to the RAP workflow required throughout



Interpretation

RAP-generated, patient-level feedback constitutes an effective mechanism to achieve rapid and sustained improvements in MRSA admission screening rates.

Relatively-speaking: extremely resource- and time-efficient.



Discussion

The relatively modest baseline compliance with MRSA admission screening compliance is not unexpected

Published benchmarks point at varying performance levels:

- Swiss study, **baseline compliance rate of 32%** (Ref 33)
- English study, **only 61% of emergency admissions** (median 67.3%), screened for MRSA (Ref 34).
- Scottish study, **audit data from self-selected areas, compliance of 81%** (Ref 5).



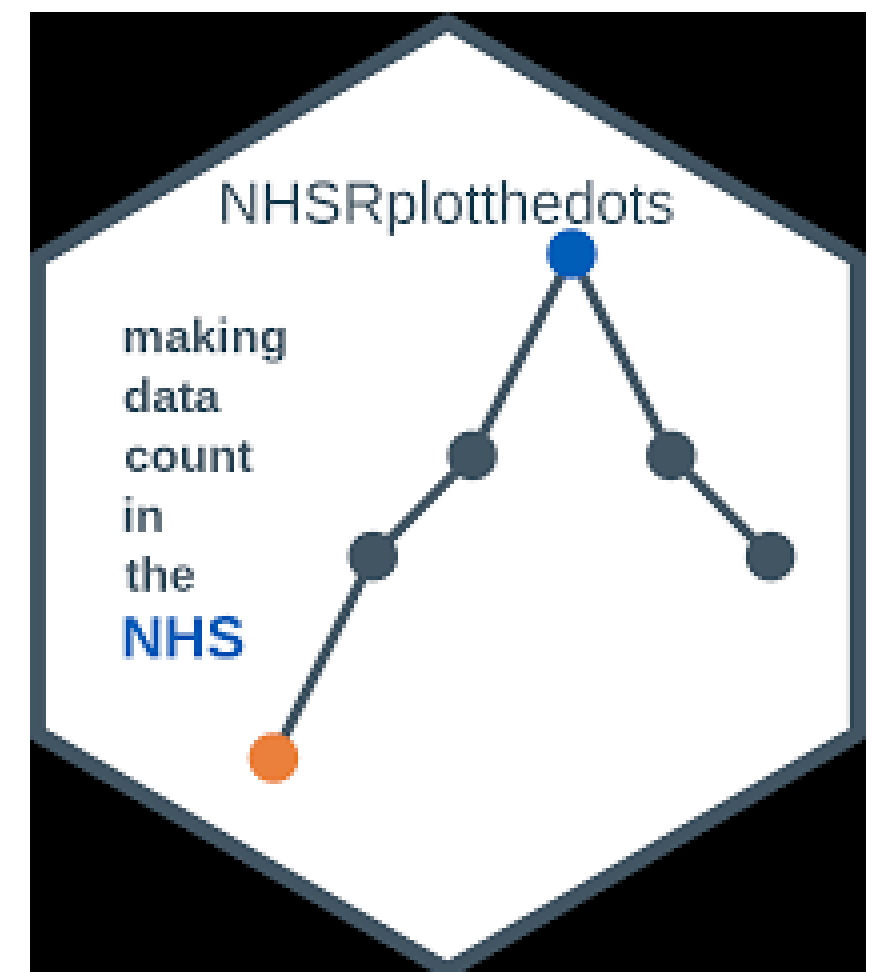
Conclusions



Beyond MRSA admission screening, **RAP can be readily modified to monitor and improve compliance with other time-sensitive measures.**

At NUTH, the RAP has been modified to...

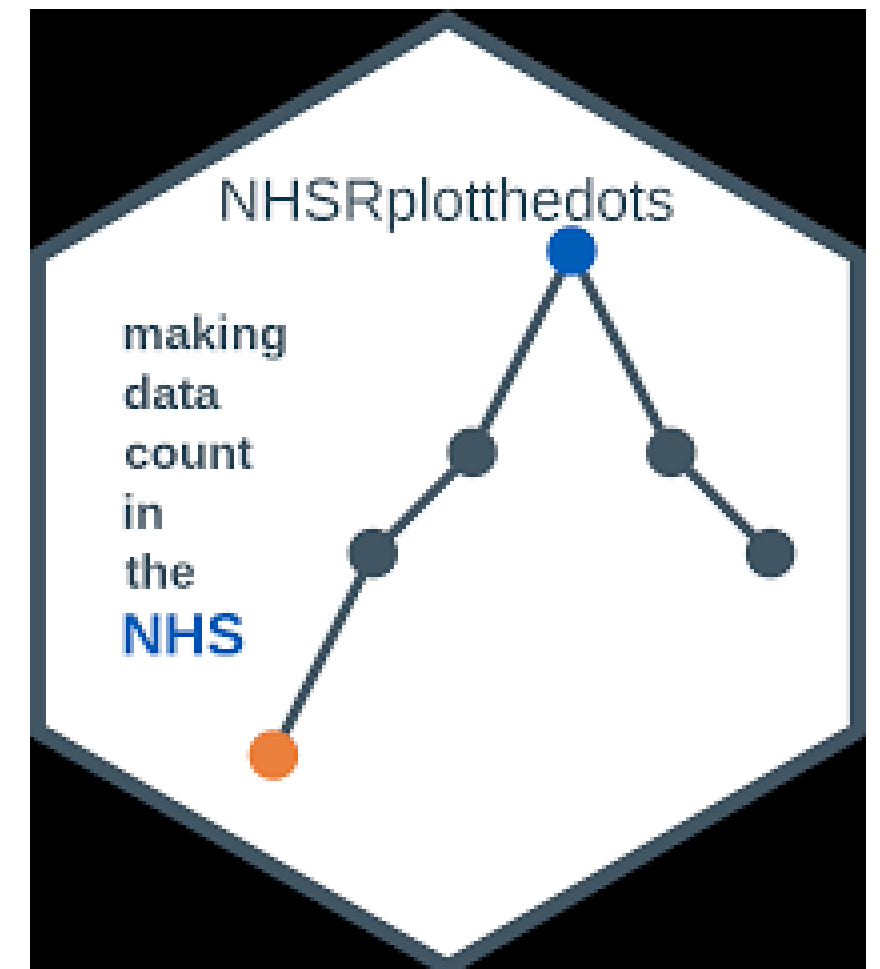
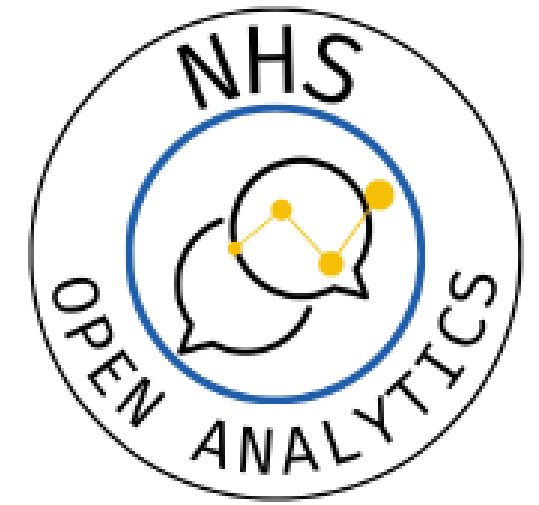
- ... Identify gaps in lipid disorder management & improve genetic screening for inherited rare disorders; and
- ... Link antimicrobial resistance (AMR) data with inpatient antimicrobial prescriptions; and
- ... Support pharmacogenetics interventions; and
- ... Identify penicillin allergy delabelling opportunities; and
- ... (and shortly also) improve recruitment to clinical trials for patients with bronchiectasis and COPD



Recommendations

Investing in RAP represents a **strategic opportunity** for healthcare organisations committed to embedding evidence-based practices.

RAP should be **further scaled across organisations to achieve sustained, system-wide improvement** in multiple dimensions of healthcare safety and quality.



This work has been submitted for publication in peer-reviewed journal

Preprint available on Zenodo:

<https://zenodo.org/records/18468788>

There are very few peer-reviewed publications on RAP (n = 5 in Nov 2025)

The screenshot shows the Ovid search interface. At the top, there is a navigation bar with the Ovid logo and links for 'My Account', 'My PayPerView', 'Support & Training', 'Help', 'Feedback', and 'Log Off'. Below this is a blue navigation bar with 'Search' selected, and other options like 'Journals', 'Books', 'Multimedia', 'My Workspace', and 'What's New'. The main content area shows a 'Search History (1)' section with a 'View Saved' link and a refresh icon. A table lists the search history:

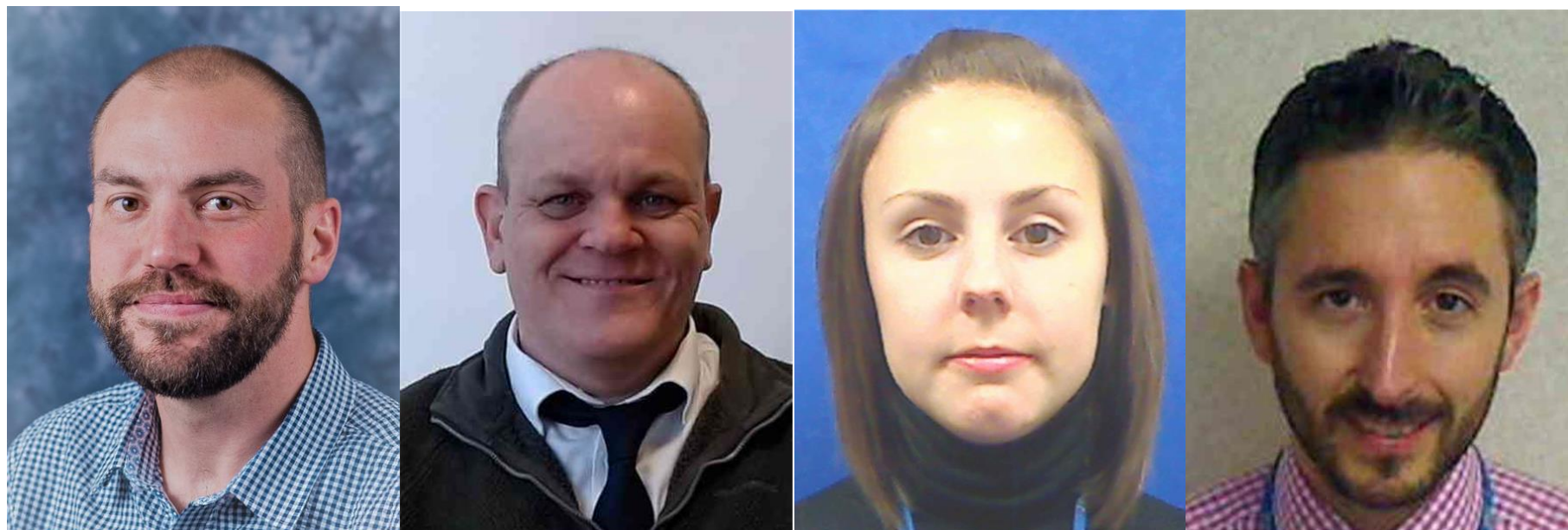
#	Searches	Results	Runtime	Type	Actions	Annotations
1	reproducible analytical pipeline.mp.	5	0.42	Advanced	Display Results More	

Below the table are buttons for 'Save', 'Remove', 'Combine with: AND OR', 'Save All', 'Edit', 'Create RSS', 'Create Auto-Alert', 'View Saved', and 'Share Search History'. A red circle highlights the 'Results' column value '5' in the table row.



Thanks for listening!

Daniel Weiland; Paul Bradley; Caroline Cullerton; Geoff Dines;



Joanne Field; Peta Le Roux; Jamie Lupton; Julie Samuel; Chris Plummer



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This presentation includes details of independent research supported by the NIHR Newcastle Biomedical Research Centre (BRC). The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.



References (1)

1. Siegel JD, Rhinehart E, Jackson M, Chiarello L. 2007 guideline for isolation precautions: Preventing transmission of infectious agents in health care settings. American Journal of Infection Control [Internet]. 2007 Dec;35(10):S65–164. Available from: <http://dx.doi.org/10.1016/j.ajic.2007.10.007>
2. NHS England. Delivering a standardised approach to screening for MRSA [Internet]. 2025. Available from: <https://gettingitrightfirsttime.co.uk/delivering-a-standardised-approach-to-screening-for-mrsa/>
3. Dickmann P, Keeping S, Döring N, Schmidt AE, Binder C, Ariño-Blasco S, et al. Communicating the risk of MRSA: The role of clinical practice, regulation and other policies in five european countries. Frontiers in Public Health [Internet]. 2017 Mar;5. Available from: <http://dx.doi.org/10.3389/fpubh.2017.00044>
4. Coia JE, Duckworth GJ, Edwards DI, Farrington M, Fry C, Humphreys H, et al. Guidelines for the control and prevention of meticillin-resistant staphylococcus aureus (MRSA) in healthcare facilities. Journal of Hospital Infection [Internet]. 2006 May;63:S1–44. Available from: <http://dx.doi.org/10.1016/j.jhin.2006.01.001>
5. Currie K, King C, McAloney-Kocaman K, Roberts NJ, MacDonald J, Dickson A, et al. Barriers and enablers to meticillin-resistant staphylococcus aureus admission screening in hospitals: A mixed-methods study. Journal of Hospital Infection [Internet]. 2019 Jan;101(1):100–8. Available from: <http://dx.doi.org/10.1016/j.jhin.2018.08.006>
6. Department of Health. Implementation of modified admission MRSA screening guidance for NHS [Internet]. 2014. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/345144/Implementation_of_modified_admission_MRSA_screening_guidance_for_NHS.pdf
7. NHS England. GIRFT guide to preoperative testing: Adult MRSA screening and suppression/eradication prophylaxis for patients who are on an elective surgical pathway [Internet]. 2025. Available from: <https://gettingitrightfirsttime.co.uk/wp-content/uploads/2025/05/GIRFT-Guide-to-preoperative-testing-MRSA-May-2025.pdf>
8. Coia JE, Wilson JA, Bak A, Marsden GL, Shimonovich M, Loveday HP, et al. Joint healthcare infection society (HIS) and infection prevention society (IPS) guidelines for the prevention and control of meticillin-resistant staphylococcus aureus (MRSA) in healthcare facilities. Journal of Hospital Infection [Internet]. 2021 Dec;118:S1–39. Available from: <http://dx.doi.org/10.1016/j.jhin.2021.09.022>
9. May C, Finch T, Rapley T. Normalization process theory. In: Nilsen P, Birken SA, editors. Handbook on implementation science [Internet]. Edward Elgar Publishing; 2020. p. 144–67. Available from: <https://www.elgaronline.com/downloadpdf/edcollchap/edcoll/9781788975988/9781788975988.00013.pdf>
10. May CR, Mair FS, Dowrick CF, Finch TL. Process evaluation for complex interventions in primary care: Understanding trials using the normalization process model. BMC Family Practice [Internet]. 2007 Jul;8(1). Available from: <http://dx.doi.org/10.1186/1471-2296-8-42>
11. Nilsen P. Making sense of implementation theories, models and frameworks. Implementation Science [Internet]. 2015 Apr;10(1). Available from: <http://dx.doi.org/10.1186/s13012-015-0242-0>
12. Murray E, Treweek S, Pope C, MacFarlane A, Ballini L, Dowrick C, et al. Normalisation process theory: A framework for developing, evaluating and implementing complex interventions. BMC Medicine [Internet]. 2010 Oct;8(1). Available from: <http://dx.doi.org/10.1186/1741-7015-8-63>
13. Goldacre B, Morley J, Hamilton N, et al. Better, broader, safer: Using health data for research and analysis [Internet]. Department of Health; Social Care; 2022. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1067053/goldacre-review-using-health-data-for-research-and-analysis.pdf
14. Elliott A. Better, broader, safer: Using health data for research and analysis (the goldacre review). Journal of Radiological Protection [Internet]. 2022 Sep;42(3):030101. Available from: <http://dx.doi.org/10.1088/1361-6498/ac89f8>
15. NHS Digital RAP Community of Practice. What is RAP? https://nhsdigital.github.io/rap-community-of-practice/introduction_to_RAP/what_is_RAP/; n.d.
16. Keegan NM, Vasselmann SE, Barnett ES, Nweji B, Carbone EA, Blum A, et al. Clinical annotations for prostate cancer research: Defining data elements, creating a reproducible analytical pipeline, and assessing data quality. The Prostate [Internet]. 2022 May;82(11):1107–16. Available from: <http://dx.doi.org/10.1002/pros.24363>
17. Newcastle upon Tyne Hospitals NHS Foundation Trust. About newcastle hospitals [Internet]. 2020 [cited 2025 Aug 21]. Available from: <https://www.newcastle-hospitals.nhs.uk/about/>



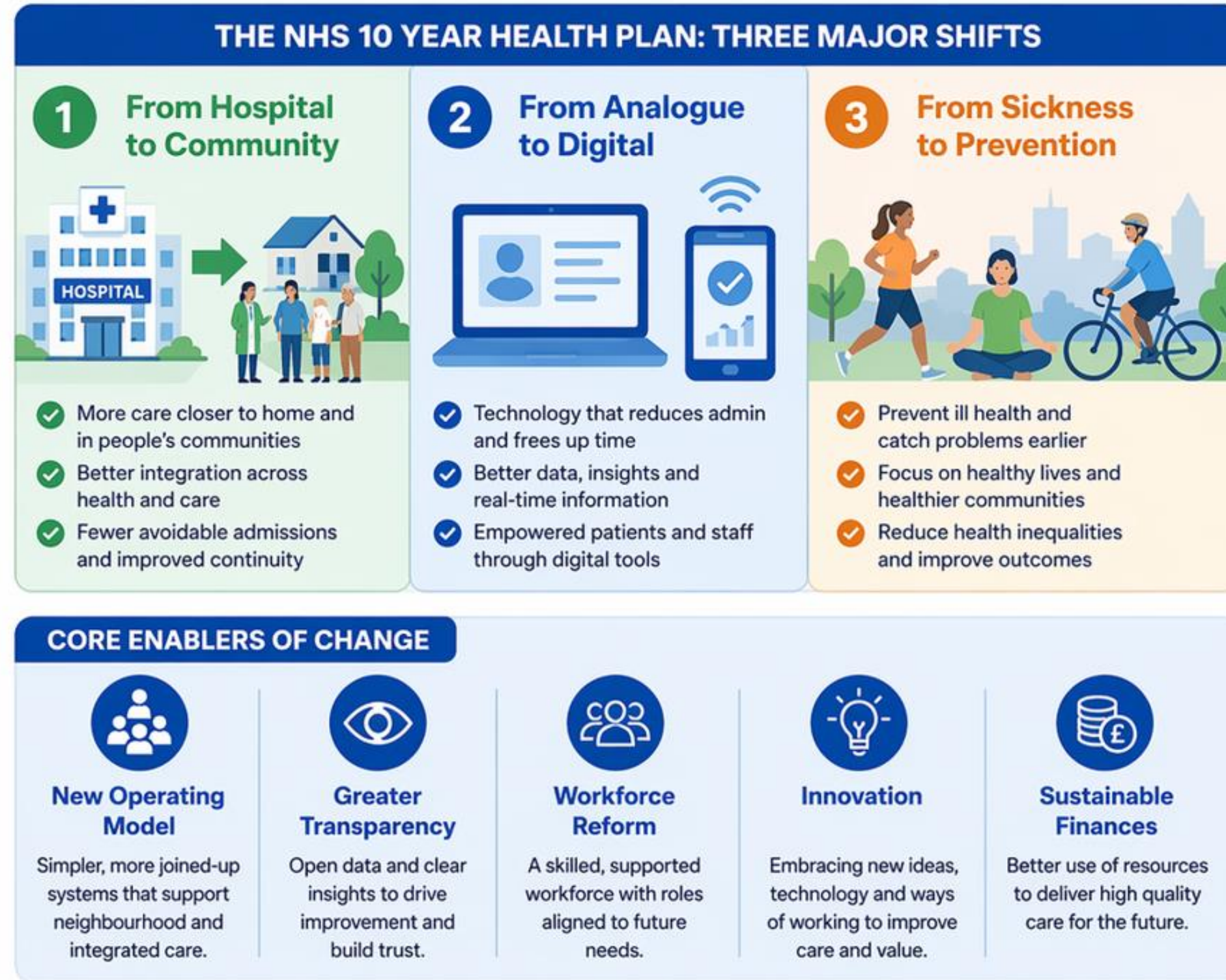
References (2)

18. Newcastle upon Tyne Hospitals NHS Foundation Trust. Newcastle hospitals laboratories. <https://laboratories.newcastle-hospitals.nhs.uk/>; 2025.
19. UKAS. Medical laboratory accreditation - ISO 15189. <https://www.ukas.com/accreditation/standards/medical-laboratory-accreditation/>; 2025.
20. NHS Digital RAP Community of Practice. Introduction to git. https://nhsdigital.github.io/rap-community-of-practice/training_resources/git/introduction-to-git/; n.d.
21. GitHub. GitHub. GitHub; <https://github.com/>; 2025.
22. Müller K, Wickham H, James DA, Falcon S. RSQLite: SQLite interface for r [Internet]. 2024. Available from: <https://rsqlite.r-dbi.org>
23. R Core Team. R: A language and environment for statistical computing [Internet]. Vienna, Austria: R Foundation for Statistical Computing; 2024. Available from: <https://www.R-project.org/>
24. Allaire J, Dervieux C. Quarto: R interface to quarto markdown publishing system [Internet]. 2024. Available from: <https://github.com/quarto-dev/quarto-r>
25. Microsoft. Internet information services (IIS) for windows server. <https://www.iis.net/overview>; 2025.
26. ICO. UK GDPR guidance and resources. ICO; <https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/>; 2025.
27. Benneyan JC. Statistical process control as a tool for research and healthcare improvement. Quality and Safety in Health Care [Internet]. 2003 Dec;12(6):458–64. Available from: <http://dx.doi.org/10.1136/qhc.12.6.458>
28. Mohammed MA. Using statistical process control to improve the quality of health care. Quality and Safety in Health Care [Internet]. 2004 Aug;13(4):243–5. Available from: <http://dx.doi.org/10.1136/qhc.13.4.243>
29. Anhøj J, Hellesøe AMB. The problem with red, amber, green: The need to avoid distraction by random variation in organisational performance measures. BMJ Quality & Safety [Internet]. 2016 Mar;26(1):81–4. Available from: <http://dx.doi.org/10.1136/bmjqs-2015-004951>
30. NHS England. Making data count [Internet]. 2019. Available from: <https://www.england.nhs.uk/publication/making-data-count/>
31. Smith T, Reading C, Wellesley-Miller S, Turner Z, Jemmett T, Mainey C, et al. NHSRplotthedots: Draw XmR charts for NHS making data count programme [Internet]. 2025. Available from: <https://nhsrplotthedots.nhsrcommunity.com>
32. Chen LF, Vander Weg MW, Hofmann DA, Reisinger HS. The hawthorne effect in infection prevention and epidemiology. Infection Control & Hospital Epidemiology [Internet]. 2015 Sep;36(12):1444–50. Available from: <http://dx.doi.org/10.1017/ice.2015.216>
33. Joubert D, Cullati S, Briot P, Righi L, Grauser D, Ourahmoune A, et al. How to improve hospital admission screening for patients at risk of multidrug-resistant organism carriage: A before-and-after interventional study and cost-effectiveness analysis. BMJ Open Quality [Internet]. 2022 Apr;11(2):e001699. Available from: <http://dx.doi.org/10.1136/bmjoc-2021-001699>
34. Fuller C, Robotham J, Savage J, Hopkins S, Deeny SR, Stone S, et al. The national one week prevalence audit of universal meticillin-resistant staphylococcus aureus (MRSA) admission screening 2012. Kluysmans J, editor. PLoS ONE [Internet]. 2013 Sep;8(9):e74219. Available from: <http://dx.doi.org/10.1371/journal.pone.0074219>



Clinical Audit and Innovation


**Vicky Patel, Clinical Effectiveness Manager,
The Rotherham Foundation Trust**




Shaping the Future Together: Innovation and Transformation

The Mindset Shift:


From Project-Based Audit to Live Improvement




Data → People → Better Care




Shaping a better future for the NHS



Traditionally, clinical audit has often been seen as a project: collect some data, produce a report, present it months later, and hope something changes. But that model is too slow for the NHS we are moving into.









The 10 Year Health Plan describes a more transparent, digitally enabled, patient-focused system, where frontline staff are empowered to reshape services.




Audit therefore needs to become a **live improvement tool** — not just a retrospective assurance exercise.


THE SHIFT WE NEED

FROM: TRADITIONAL AUDIT		TO: LIVE IMPROVEMENT
 <p>Retrospective Audit Looking back at what has already happened.</p>	➤	 <p>Continuous Learning Real-time and near real-time insights to improve care now.</p>
 <p>Compliance Focused on meeting requirements and producing reports.</p>	➤	 <p>Improvement Focused on better outcomes, reducing variation and delivering value.</p>
 <p>Central Ownership Audit designed and delivered by a few, with findings reported back.</p>	➤	 <p>Team Ownership Teams own their data, identify issues and drive change locally.</p>


ENABLERS OF THE MINDSET SHIFT




Smarter Data
Use digital tools and automation to get the right data, at the right time.




Empowered People
Build data literacy and improvement capability across all roles.




Meaningful Feedback
Provide timely, clear and actionable insights at the point of care.




Focus on Impact
Audit what matters most and can make a real difference.



Collaborative Culture
Work together across teams and systems to improve care.



Audit is not just about reporting what happened.
It's about enabling better care, together, every day.




Our goal
A learning health system where data, people and improvement drive the best outcomes for patients and communities.


Shaping the Future Together: Innovation and Transformation

Make Audit Feel Relevant to Frontline Care

Relevant audit engages teams, drives improvement, and delivers better outcomes for patients.



Better care for all, now and for the future



1. HOW TO ACHIEVE THIS

Start with service pain points, not audit topics for their own sake.
Ask:

- What is slowing teams down?
- What creates frustration for patients?
- What creates unnecessary admissions, rework, or risk?

Co-design the audit question with the frontline team, so the audit answers a question they actually care about.

Present findings quickly and visually, using simple dashboards or run charts rather than lengthy reports. This supports transparency, empowers staff and drives action.

Involve the right people, focus on what matters, and make the data easy to use. That's how audit becomes a tool for improvement, not just a tick-box exercise.

2. INNOVATIVE AUDIT EXAMPLES ALIGNED TO THE THREE SHIFTS

HOSPITAL → COMMUNITY
Audit whether patients with frailty, COPD, heart failure or recurrent falls could have been managed earlier through neighbourhood or community pathways rather than admitted to hospital.

SICKNESS → PREVENTION
Audit missed opportunities for prevention during emergency attendances – for example:

- smoking cessation referral
- alcohol intervention
- weight advice
- hypertension identification
- vaccination status
- falls prevention advice

ANALOGUE → DIGITAL
Audit where delays are caused by:





- paper forms
- duplicate data entry
- non-interoperable systems
- lack of digital tasking / workflows



3. MOTIVATING MESSAGE

“ If audit helps teams fix what makes their day harder, they will use it.

If it feels like extra paperwork with no visible benefit, they won't. ”

Why this matters

-  Helps solve today's problems, not just report on yesterday.
-  Builds engagement, ownership and trust.
-  Drives quicker, meaningful improvements.
-  Improves patient experience, safety and outcomes.

 **Relevant audit. Real insights. Better care.** | Working together to build the NHS of the future. 

Shaping the Future Together: Innovation and Transformation

Reduce Effort: Embed Audit Into Workflow

Smarter audit. Less burden. Better care.



The biggest barrier to engagement is often not resistance to improvement – it is workload. So we have to redesign audit so it sits within workflow rather than on top of workflow.



The digital shift in the 10 Year Health Plan is specifically about reducing admin burden and enabling staff to use technology more effectively.



Less extra work.
More meaningful data.
Better outcomes.

1. HOW TO ACHIEVE THIS



Use existing electronic patient record fields wherever possible instead of separate data collection tools.



Build short mandatory prompts into documentation for key quality measures.



Automate extraction of standard measures rather than manually reviewing every case.



Use sampling intelligently rather than auditing everything. The objective is actionable intelligence, not maximum burden.



This approach supports productivity and efficiency goals in planning guidance.

2. INNOVATIVE AUDIT EXAMPLES



Digital escalation documentation
Audit completion of digital escalation documentation in deteriorating patients rather than collecting separate paper audit forms.



Timely antibiotics in sepsis/CAP
Audit whether electronic prescribing systems trigger timely antibiotics in suspected sepsis or community-acquired pneumonia.



Discharge summaries and community follow-up
Audit whether discharge summaries are sent promptly and include community follow-up actions, supporting continuity and the shift from hospital to community.

3. MOTIVATING MESSAGE

“ If the data are already there, audit becomes easier.

And if audit becomes easier, improvement becomes more likely. ”

WHY THIS MATTERS



Reduces duplication and admin burden.



Frees up time for direct patient care.



Delivers timely, reliable insights.



Supports better decisions and better care.



Embed audit in the work, not on top of it.

When audit is easier, improvement happens.



Shaping the Future Together: Innovation and Transformation

Move from Annual Audits to Rapid-Cycle Improvement

Faster learning. Real-time impact. Better care.



The 10 Year Health Plan empowers frontline staff to reshape services. We need audit cycles that are rapid enough to influence practice in real time.

1. HOW TO ACHIEVE THIS

Use small, focused audits over 1–2 weeks rather than large projects over 6 months.

Combine audit with PDSA-style improvement cycles: test, learn, refine, retest.

Feed results back quickly at huddles, ward meetings, specialty meetings, and safety briefings – not just formal committees.

Short cycles. Quick feedback. Continuous improvement.

2. INNOVATIVE AUDIT EXAMPLES ALIGNED TO THE THREE SHIFTS

HOSPITAL → COMMUNITY
Rapid audit of patients attending ED from care homes or those with ambulatory-sensitive conditions to identify who could have been redirected or supported earlier in the community.

ANALOGUE → DIGITAL
2-week audit of digital referral turnaround times from ED to specialty advice, or referral-to-review times using timestamped electronic data.

SICKNESS → PREVENTION
Rapid audit of whether risk factors are identified and acted on during outpatient or admission episodes – e.g. obesity, frailty, smoking, alcohol or social isolation.

Focus on actionable insights that lead to better decisions and better outcomes.

3. MOTIVATING MESSAGE

“ People are motivated when they can see change happening quickly. Momentum matters. ”

WHY THIS MATTERS

- Improves care faster.
- Reduces variation and waste.
- Empowers frontline teams.
- Better outcomes for patients, communities and staff.



From slow and retrospective to fast and responsive.

Audit that drives change, every day.



Shaping the Future Together: Innovation and Transformation

HOSPITAL → COMMUNITY

Moving care closer to home

The plan wants more care delivered closer to home, through neighbourhood and community-based models, with less avoidable fragmentation and duplication.

Better care, closer to home, with seamless support.

WHY THIS MATTERS

- More care closer to home improves patient experience and outcomes.
- Reduces pressure on hospitals and frees up capacity for those who need it most.
- Better use of resources and reduced avoidable costs.
- Stronger integration across health and social care.

Audit is a key tool to ensure care is delivered in the right place, at the right time.

WHAT TO AUDIT

- 1. Avoidable admissions**
 Audit avoidable admissions for conditions that could be managed through community pathways.
- 2. Delays in discharge**
 Audit delays in discharge caused by poor coordination, documentation, transport, pharmacy, or follow-up arrangements.
- 3. Timely and complete referrals**
 Audit whether referrals to community services, virtual wards, falls services, heart failure teams, COPD teams, or district nursing are timely and complete.
- 4. Follow-up burden**
 Audit follow-up burden: are patients returning to hospital for things that could be done remotely, virtually, or in the community?

INNOVATIVE EXAMPLE: AUDIT THE WHOLE PATHWAY

“ Instead of auditing only inpatient care, audit the whole pathway from admission through discharge to community follow-up. That shifts the audit lens from a hospital episode to a patient journey. ”

Admission

- Was admission necessary?
- Could earlier community support have prevented it?

Inpatient care

- Was care appropriate and timely?
- Were discharge plans started early?

Discharge

- Was discharge timely?
- Was information complete and shared?

Community follow-up

- Was referral received and actioned?
- Did the patient receive the right support?

Outcomes

- Did the patient avoid re-admission?
- What is the patient experience?

Focus on the patient journey. Improve every step.

Better experience for patients and carers

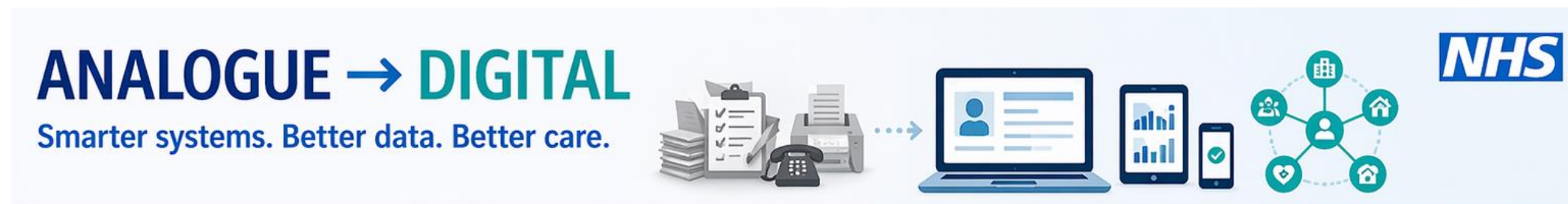
More care in the community, with fewer hospital stays

Stronger, joined-up neighbourhood services

Reduced duplication, delays and readmissions

Healthier communities and better outcomes for all

Shaping the Future Together: Innovation and Transformation



WHY THIS MATTERS	WHAT TO AUDIT	INNOVATIVE AUDIT EXAMPLE				
<ul style="list-style-type: none"> Technology should reduce admin burden and duplication, freeing up time for direct care. Improve access and patient control through digital tools that are easy to use and accessible to all. Support integration across services and care settings, enabling joined-up, person-centred care. Enable better patient outcomes and improve staff productivity. Engagement findings highlight the need to get the basics right – interoperable systems, usable records, and fit-for-purpose digital infrastructure. 	<ol style="list-style-type: none"> Quality and completeness of structured electronic documentation. Missed or delayed clinical actions due to non-digital or fragmented workflows. Uptake and equity of digital patient tools: online booking, remote monitoring, digital PROMs/PREMs, patient portals. Whether teams are still duplicating work across multiple systems. 	<p> Audit whether electronic NEWS2 escalation creates faster review than traditional verbal escalation alone.</p> <p>This turns audit into a test of whether digital tools are really improving care.</p> <table border="1"> <thead> <tr> <th data-bbox="1945 874 2192 902">DIGITAL NEWS2 ESCALATION</th> <th data-bbox="2259 874 2558 902">TRADITIONAL VERBAL ESCALATION</th> </tr> </thead> <tbody> <tr> <td data-bbox="1945 902 2192 1146"> NEWS2 Escalation triggered 7 Faster review Better outcomes </td> <td data-bbox="2259 902 2558 1146"> VS Slower review Higher risk of delay </td> </tr> </tbody> </table> <p> Measure impact. Drive improvement. Deliver better care.</p>	DIGITAL NEWS2 ESCALATION	TRADITIONAL VERBAL ESCALATION	NEWS2 Escalation triggered 7 Faster review Better outcomes	VS Slower review Higher risk of delay
DIGITAL NEWS2 ESCALATION	TRADITIONAL VERBAL ESCALATION					
NEWS2 Escalation triggered 7 Faster review Better outcomes	VS Slower review Higher risk of delay					

THE ENABLERS OF SUCCESS

- Interoperable systems that connect care.
- Usable, high-quality records that support decision-making.
- Fit-for-purpose digital infrastructure that is reliable, secure and resilient.
- Digital capability and support for staff and patients.
- Continuous audit and feedback to drive ongoing improvement.

Shaping the Future Together: Innovation and Transformation

SICKNESS → PREVENTION

Prevent ill health. Reach patients earlier.
Make the healthy choice the easy choice.

The 10 Year Health Plan explicitly aims to reach patients earlier, prevent ill health, and make the healthy choice the easy choice.

WHY THIS MATTERS

WHAT TO AUDIT

INNOVATIVE AUDIT EXAMPLE

- Prevent illness before it starts**
Early identification and support reduce the risk of developing serious disease.
- Improve outcomes and quality of life**
Prevention helps people stay well for longer and live healthier lives.
- Reduce avoidable admissions and pressure on services**
Effective prevention reduces escalation and repeat attendances.
- Reduce health inequalities**
Targeted prevention ensures everyone has the best opportunity for good health.

A prevention-focused approach supports the shift from treatment to prevention at every point of care.

- Recording and action on modifiable risk factors**
Smoking, obesity, high blood pressure, alcohol, falls risk, frailty and more.
- Missed opportunities for prevention or proactive management**
Were there earlier opportunities to identify risk, intervene or support this patient?
- Screening and identification of patients at risk of repeated admission**
Are validated tools used? Are high-risk patients flagged and reviewed?
- Prevention advice and onward referral**
Is advice given, documented and understood? Are referrals to prevention services completed and followed up?

“ Audit not just whether a patient was treated safely after deterioration, but whether there had been missed opportunities to prevent the deterioration in the first place. ”

Identify risk earlier
Screen, assess and capture risk factors

Intervene proactively
Give advice, start support, make referrals

Prevent deterioration
Support behaviour change and risk reduction

Better outcomes and experiences
Fewer episodes, fewer admissions, healthier lives

This shifts the audit lens from reacting to events to preventing them.

KEY OUTCOMES OF THIS APPROACH

Fewer emergency attendances and admissions

Better health outcomes for patients

Reducing health inequalities

Better use of resources

A prevention-focused NHS for the future

Shaping the Future Together: Innovation and Transformation

Give Teams Ownership of Their Own Data

See it. Understand it. Act on it.

The 10 Year Health Plan talks about a more transparent NHS and a system where frontline staff are empowered.

Teams should be able to see their own performance and act on it – no need to wait for a central report.

Empowered teams

Better decisions

Better care

HOW TO ACHIEVE THIS

- Create ward-, service-, or specialty-level dashboards.
Put real-time information at the point of care where it drives improvement.
- Use simple metrics with clear definitions and visual trends.
Make data easy to understand, consistent and actionable.
- Compare current month to previous month.
Focus on short, regular cycles rather than waiting for annual reports.
- Include patient stories or pathway examples.
Bring the numbers to life and reflect what matters to patients – choice, control and experience.
- When teams own their data, they own the improvement.

INNOVATIVE AUDIT EXAMPLES

SPECIALTY DASHBOARD EXAMPLE

Key measures that matter to your specialty, updated in real time.

<p>Escalation to Review (mins)</p> <p style="font-size: x-large; font-weight: bold;">28</p> <p style="font-size: x-small;">▼ 12% vs last month</p>	<p>Sepsis Bundle Compliance</p> <p style="font-size: x-large; font-weight: bold;">86%</p> <p style="font-size: x-small;">▲ 8% vs last month</p>	<p>Discharge Before Noon</p> <p style="font-size: x-large; font-weight: bold;">62%</p> <p style="font-size: x-small;">▼ 5% vs last month</p>	<p>Referral Completion to Community</p> <p style="font-size: x-large; font-weight: bold;">91%</p> <p style="font-size: x-small;">▲ 6% vs last month</p>
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Trend over time (last 6 months)

THEATRE / CLINIC DASHBOARD EXAMPLE

Operational and patient experience metrics for your service.

<p>Did Not Attend (DNA) Rate</p> <p style="font-size: x-large; font-weight: bold;">7.4%</p> <p style="font-size: x-small;">▼ 1.2pp vs last month</p>	<p>Digital Pre-assessment Completion</p> <p style="font-size: x-large; font-weight: bold;">78%</p> <p style="font-size: x-small;">▲ 9% vs last month</p>	<p>Virtual Follow-up Conversion Rate</p> <p style="font-size: x-large; font-weight: bold;">64%</p> <p style="font-size: x-small;">▲ 11% vs last month</p>	<p>Patient Experience Score (PROMs)</p> <p style="font-size: x-large; font-weight: bold;">8.6/10</p> <p style="font-size: x-small;">▲ 0.7 vs last month</p>
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Updated weekly
Visible to the whole team
Actionable every day

Right data. Right time. Right people.
Driving improvement where it happens.

MOTIVATING MESSAGE

“ People care more about data when they can see themselves in it. ”

WHY THIS MATTERS

- Increases visibility and transparency.
- Builds engagement and ownership.
- Speeds up decisions and action.
- Improves outcomes and patient experience.
- Supports a culture of continuous learning and improvement.

When teams see it, they own it. When teams own it, they change it.

Empowering staff. Improving care.
Delivering the future NHS.


Shaping the Future Together: Innovation and Transformation

Build Capability, Confidence and Clinical Leadership

Equipping our people to use data with confidence, lead improvement and transform care.




The 10 Year Health Plan prioritises workforce reform and innovation as key enablers of change.

 Motivation is not just about tools — it is about confidence. If we want teams to use audit differently, we have to equip them differently. That means building data literacy, improvement capability, and clinical leadership.

1. HOW TO ACHIEVE THIS

- Train teams in key skills**
 - Interpreting variation
 - Using run charts
 - Asking good improvement questions
 - Designing simple measures that matter
- Develop clinical leadership**

Identify and develop specialty clinical effectiveness leads or audit champions who can translate data into practice change.
- Empower frontline teams**

Support teams to lead small, focused local audits and improvement projects, not just rely on central teams.

 Invest in people. Build skills. Strengthen leadership. Create a culture of learning and improvement.

2. INNOVATIVE AUDIT EXAMPLES

- NURSE-LED AUDIT**

Deterioration recognition and documented response
Audit compliance with NEWS2 escalation and documented actions, and impact on timely review.


- AHP-LED AUDIT**

Discharge readiness and community handover
Audit completion and quality of discharge planning and handover to community services.


- JUNIOR DOCTOR-LED AUDIT**

Delays caused by paper-to-digital duplication
Rapid audit of time lost due to duplicate data entry and non-digital processes, and where improvements can be made.



 Small audits. Real problems. Local solutions. Rapid learning and improvement.

3. MOTIVATING MESSAGE

“ When staff feel capable of using data, they stop seeing audit as compliance and start seeing it as influence. ”

-  Builds confidence and capability across all roles.
-  Empowers teams to make data-driven decisions.
-  Strengthens clinical leadership at every level.
-  Improves care, experience and outcomes for patients.

 Confident people. Strong leaders. Better data use. Better care.



Shaping the Future Together: Innovation and Transformation

Focus on Fewer Audits, but Make Them Higher Value



Less volume.
More impact.
Better care.



WHY THIS MATTERS
In a resource-constrained environment, one of the most important things we can do is stop trying to audit everything. The priority should be **fewer audits with stronger alignment** to strategic priorities, patient outcomes, inequalities, and operational pain points.

HIGH-VALUE AUDIT DELIVERS:

- Better outcomes
- Better experience
- Less waste and duplication
- Faster action and improvement
- Reduced inequalities

1. HOW TO ACHIEVE THIS

- Support one or more of the three shifts**
Hospital → Community, Analogue → Digital, Sickness → Prevention.
 - Reduce waste, duplication, delay, or avoidable admission**
Focus on areas that create the biggest operational and clinical impact.
 - Improve experience, continuity, prevention, or access**
Choose audits that improve what matters most to patients and staff.
 - Can be measured quickly and acted on locally**
Select projects that generate timely insights and enable rapid improvement.
- Not everything needs an audit – only what will drive meaningful improvement.

2. EXAMPLES OF HIGH-VALUE TRANSFORMATIVE AUDIT TOPICS

- Equity of access to digital services or virtual pathways**
Audit who is and isn't able to access digital tools and virtual care. Identify gaps and barriers to ensure equitable access for all.
- Neighbourhood pathway audits for patients with repeated admissions**
Review whole-person pathways for patients with frequent admissions to identify earlier support and prevent avoidable hospital use.
- Prevention audits for obesity, smoking, frailty, falls, alcohol, and hypertension**
Audit identification, advice, and onward referral for modifiable risk factors. Turn every contact into an opportunity for prevention.
- Pathway completion audits across organisational boundaries**
Follow the patient journey end-to-end – from referral to community follow-up – to identify breaks and improve continuity of care.
- Digital workflow audits to reduce wasted clinical time**
Identify where poor system design, duplication or manual processes waste time and slow patient care.

FROM
 High volume, low impact
Too many audits, limited insights, minimal change.

TO
 Fewer audits, stronger focus, greater impact
Actionable insights, aligned to priorities, driving better outcomes.

**Better data.
Better decisions.
Better care.**

Shaping the Future Together: Innovation and Transformation

In the NHS of the future, clinical audit should not sit at the edge of service delivery – it should sit at the heart of how teams learn, adapt and improve.

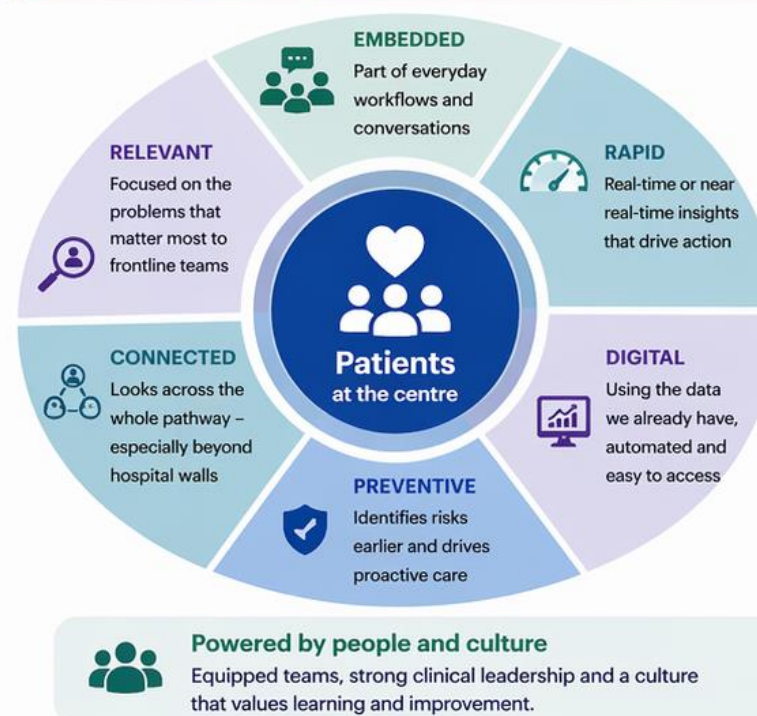


Better data.
Better decisions.
Better care.

TODAY: AUDIT OFTEN SITS AT THE EDGE

- Retrospective and slow**
Reports arrive months later when opportunities to change have passed.
 - Seen as a burden**
Extra work, disconnected from day-to-day care.
 - Focused within hospital walls**
Limited visibility of the whole patient pathway.
 - Compliance-driven**
Ticks boxes rather than drives improvement.
- The result: missed opportunities, duplication, frustration and poor outcomes.

THE FUTURE: AUDIT AT THE HEART OF CARE



WHAT THIS ENABLES

- Better intelligence, faster**
Teams see what is happening now and can act in real time.
- Empowered teams**
Staff own their data and drive improvement locally.
- Better outcomes**
Earlier intervention, reduced variation and safer, higher-quality care.
- Improved experience**
More joined-up, person-centred care across settings.
- More efficient use of resources**
Less waste, duplication and avoidable admissions.
- Audit becomes a driver of improvement, not just a measure of performance.**

A SHIFT IN PURPOSE



THE BOTTOM LINE

Clinical audit is not something we do to teams. It is something we do with teams – to learn, adapt and improve every day.



When audit sits at the heart of service delivery, we build a learning health system where data, people and improvement come together to deliver the best care for all.

Better for patients.
Better for staff.
Better for the NHS.



Shaping the Future Together: Innovation and Transformation

Clinical Audit at the Heart of the Future NHS

From burden to transformation

Smarter audit. Faster insight. Better care.

1 Opening – Set the vision

Health and care are changing rapidly, and clinical audit has to change with them.

If we want audit to help deliver the NHS 10 Year Health Plan, we need to use it differently.

Key message: This is not about doing more audit — it's about doing audit differently.

2 The challenge today

Too often, clinical audit still sits at the edge:

- Retrospective
- Report-driven
- Disconnected from care
- Seen as a burden

By the time the data is presented, the opportunity to act has often already passed.

3 The core issue

The issue isn't effort — it's the model.

A model that's too slow, too separate, and too focused on reporting rather than improving.

4 What needs to change

- More relevant**
Focused on real frontline problems
- More embedded**
Part of everyday care
- More rapid**
Delivering insight in real time
- More digital**
Using data we already have
- More preventive**
Identifying risk earlier
- More connected**
Across the whole pathway, especially beyond hospital walls

5 The mindset shift

Not bigger

- More reports
- More data collection
- More bureaucracy

Smarter

- Better intelligence
- Faster insight
- Actionable information

Supporting teams to act in real time and improve care.

6 From → To

FROM	TO
Retrospective	Real-time
Projects	Continuous improvement
Hospital-focused	Whole pathway
Compliance	Improvement

7 What this enables

- Faster decisions
- Earlier intervention
- Reduced variation
- Better outcomes
- Better experience
- More efficient use of resources

Better data
→
Better decisions
→
Better care

8 The transformation

- From measuring performance to driving improvement
- From compliance activity to clinical decision support
- From standalone projects to continuous learning

Audit becomes a driver of transformation.

9 The future state

Embedded in care. Focused on outcomes. Driven by teams.

10 The key message

“Clinical audit should not sit at the edge of service delivery — it should sit at the heart of how teams learn, adapt and improve.”

11 Final close

Not something we do to teams — something we use with teams.

Every day, to learn, adapt and improve.

When audit is embedded in everyday care, it doesn't just measure quality — it helps create it.

Smarter audit. Faster insight. Better care.

Q+A

Daniel Weiland

Vicky Patel

Upcoming Clinical Audit Awareness Week Webinars

Daily themed webinars:

- Thu 10.30am-12pm: Patient Safety: Using Data to Reduce Harm
- Fri 10am-12pm & 1-3pm: Data-Informed Improvement

Daily Excellence in Clinical Audit Awards announcements:

- Thu 12.45-1.30pm: Patient Safety Award
- Fri, during the 1-3pm webinar: Evidence in Practice Award



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

www.hqip.org.uk/caaw26

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

www.hqip.org.uk/impact-of-data/supporting-strategy-and-delivery

THANK YOU!



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