Q1 – Yes this reflects the general concerns of clinical audit staff, not just in trusts but for community and primary care providers also, although the experiences differ in individual organisations

Q2 – Yes, organisations need clear central guidance about the role and importance of clinical audit to reverse the erosion

Q3 –

1. I agree the understanding of clinical audit is a hinderence however would disagree with any suggestion to use alternative terminology as this would cause only further confusion, it would be more useful to use the full term ‘clinical audit’ consistently rather than abbreviating to ‘audit’ and to have national clear message to organisations about clinical audit

2. and 3. Clinical audit staff should be part of central ‘Quality and Safety’ or ‘Governance’ teams but not integrated into clinical teams, which would endanger professional identity and development, reduce economies of scale such as for specialist software, and may result in clinical audit staff being pulled into non-clinical audit work such as activity counts.

4. Commercial sensitivities and competitiveness limit sharing between clinical audit staff in different organisations, but organisations need their own local clinical audit staff to support local clinical audits so it would be worse to have clinical audit staff just for national audits. More available templates and guidance for local staff would be preferable to reduce re-inventing the wheel but it should be recognised that one size does not fit all and the skill of local clinical audit staff is to personalise tools to fit their organisation

5. Agree – clinical audit staff need to be enabled with the capacity and the skills to deliver regular programmes of clinical audit training to improve skills of clinicians

Q4 – Yes to an extent but not as the only measure

Q5 – Yes, this wider context would be useful to staff in large organisations not exposed to such things

Q6 – No, there is a risk of diluting skills and work of clinical audit staff and the risk of losing objectivity if integrated wholely with clinical staff. Clinical audit staff should be valued in our own right (as researchers are) not riding on the status/ prestige of clinicians working alongside.

Q7 – Yes

Q8 – Facilitating exchanges of information between organisations is useful to an extent but the limiting factor is commercial sensitivity and competitiveness between organisations, particularly those local to each other who may be competing for the same business

Q9 –

1. Agree

2. Yes to having Quality Departments but within the departments should be specific clinical audit staff (not quality staff with some remit for clinical audit) and the quality department should be central not within clinical divisions

3. Agree

4. Agree but with awareness that commercial sensitivies and competitiveness limits sharing

5. Agree