Trust Policy

University Hospitals Plymouth NHS Trust

Clinical Audit Policy

Issue Date	Review Date	Version
May 2018	May 2023	8

Purpose

Clinical audit underpins several quality improvement areas for the Trust, particularly:

- Demonstrating clinical governance
- Promoting and enabling best practice
- Improving patient experience and outcomes
- Facilitating corporate learning
- Encouraging staff development

Who should read this document?

This policy has been developed for all Trust staff but is directly applicable to:

- Staff undertaking or involved in clinical audit, service evaluation or quality improvement projects
- Service Line Clinical Directors/Managers
- Clinical Governance and Service Line Audit Leads

Key Messages

Clinical audit is a quality improvement process that seeks to measure and improve patient care through systematic review and comparison with best practice standards, and is used to drive improvement to the services and care we provide.

This policy aims to promote a seamless, collaborative approach to clinical audit that will enhance the quality of care given to patients and be of significant benefit to all services.

In addition this policy sets out the responsibilities for all Service Lines to ensure that the Trust has an effective Clinical Audit Programme that can demonstrate the delivery of patient-centred and high quality care that corresponds with national and local priorities

The audit priorities are as follows:

Audit Priority	Summary	Example
Priority 1	External must do	National audit participation
Priority 2	Corporate must do	Clinical record keeping
Priority 3	Service Line must do	NICE guidance
Priority 4	Specialist Interest	----

Core accountabilities	
Owner	Deputy Audit, Assurance and Effectiveness Manager
Review	Clinical Effectiveness Group
Ratification	Medical Director/Assistant Medical Director for Quality and Safety
Dissemination (Raising Awareness)	Deputy Audit, Assurance and Effectiveness Manager
Compliance	Clinical Effectiveness Group

Links to other policies and procedures
Clinical Records Keeping Policy Health Records Policy Management and Implementation of National Guidance and Enquiries Policy

Version History		
3	August 2010	Approved by Clinical Governance Steering Group (CGSG)
4	April 2011	Approved by CGSG
5	June 2012	Approved by CGSG
5.3	March 2014	Twelve month extension agreed by the Medical Director
5.4	October 2014	Six month extension agreed by the Medical Director
6	May 2015	Approved by Clinical Effectiveness Group
7	September 2016	Amendment to CG Lead audit approval
8	May 2018	Amendments to job titles and reporting requirements

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents on StaffNET. Larger text, Braille and Audio versions can be made available upon request.

Contents

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1 Introduction

Clinical audit is a snapshot of clinical practice or process at a given time measured against a gold standard.
It is a process cycle used to evidence compliance and promote quality improvement processes leading to innovations in patient care and improved outcomes through systematic review.
This policy sets out how clinical audit is undertaken in an open, efficient and robust way and explains the Trust focus on learning and improvement outcomes to ensure effective change can be implemented.

2 Purpose

Clinical audit is used by the Trust to demonstrate the delivery of patient-centred, high quality care that corresponds with national and local priorities or assessments.

This policy explains the establishment of audit priorities, the decision process on how they are approved, and their internal/external reporting arrangements. It also explains the internal Clinical Audit Programme.

Clinical Audit participation may be used as a component of clinical staff revalidation processes and provides evidence of personal development for trainee staff. Most importantly it helps us to assess the provision we make to our patients to ensure it is of the highest standard and where this is not the case to take remedial action. Professional regulatory body membership often requires demonstration of regular evaluation or review of own work or evidence of quality improvement activities.

3 Definitions

Clinical audit

Clinical audit is a quality improvement process that seeks to measure and improve patient care through systematic review and comparison with best practice standards, and is used to drive improvement to the services and care we provide.

National audit

National clinical audit is designed to improve patient outcomes across a wide range of medical, surgical, therapy and mental health conditions. Its purpose is to engage all healthcare professionals across England and Wales in systematic evaluation of their clinical practice against standards, to systematically evaluate and improve care and to create the impetus for system wide change. It is mandated that we take part in such audit and reflects our intent to be providers of the highest standards of care.

Service Evaluation

Service evaluation uses systemic rigorous methods to describe and investigate the efficiency and effectiveness of an established service or clinical intervention with the purpose of generating
information that is of local significance.

Quality Improvement (QI) Project

Clinical audit is frequently used to provide baseline data for Quality improvement projects.. The results and recommendations of clinical audits and service evaluations provide snap shot summaries of current position. QI methodologies may then be used to systematically

promote positive change using measurement techniques to demonstrate that the changes implemented are improvements.

Research
Research is an attempt to derive generalisable new knowledge by addressing clearly defined questions with systematic and rigorous methods.

Healthcare Quality Improvement Partnership (HQIP)
HQIP was established to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales. Each year HQIP publish the list of all national audits that Trust participation is required in and that will be included in the end of financial year quality account.

Quality Account
A Quality Account is a report published annually about the quality of services by an NHS healthcare provider. This provides a statement of the quality of services and care that have been provided in the previous year and the plans and objectives for ongoing delivery of high quality services into the year ahead.

4 Duties

Medical Director
The Medical Director is accountable for ensuring that the Trust has an effective clinical audit programme in place.

Deputy Audit, Assurance and Effectiveness Manager
The Deputy Audit, Assurance and Effectiveness Manager is responsible for ensuring that an effective clinical audit service is provided to the Trust. The Deputy Audit, Assurance and Effectiveness Manager is also responsible for the development of the Trust's clinical audit programme for Priority 1 and 2 audits and for encouraging the identification and agreement of priority 3 and 4 audits within service lines/care groups that are suitably linked with internal processes such as NICE guidance and safety alerts.

The Deputy Audit, Assurance and Effectiveness Manager is also required to:

- Work with clinical audit or clinical governance leads as appropriate to ensure that the clinical audit programme is implemented in Care Groups as agreed.
- Prepare reports for the Head of Audit, Assurance and Effectiveness on the implementation and outputs of the clinical audit programme for reporting both internally and externally.
- Take ownership of the clinical audit policy ensuring that its requirements are communicated and understood and that the policy is regularly reviewed and updated to reflect best practice.
- Keep abreast of national developments in Clinical Audit and related best practice.

Clinical Effectiveness Administrator
The Clinical Effectiveness Administrator is responsible for:

- Providing advice to staff registering or completing clinical audit work;
- Supporting the review process of audit proposals and results
- Facilitating access to patient case notes for corporate priority audits
- Maintaining a register of all registered clinical audit activity undertaken within the Trust.

- Monitoring compliance against the Trust's audit plan

Assistant Medical Director for Quality and Safety
The Assistant Medical Director for Quality and Safety is responsible for the review of clinical audit proposal forms in the absence of Service Line, Care Group or Subject Expert Lead approval or where the proposed audit potentially has an impact on, or is linked to, a Trust priority in order to provide constructive feedback in relation to the clinical content, structure and measured activity to ensure maximum effectiveness is achieved.

The Assistant Medical Director for Quality and Safety is responsible for reviewing all clinical audit results once presented to Service Line Clinical Governance meetings or equivalent forum. A particular focus is to determine where opportunities exist for the development of audits into Quality Improvement projects. The AMD will provide support and direction for teams engaging in QI through the Trust QI framework.

The Assistant Medical Director for Quality and Safety will enlist the support of specialists as required to review audit content and provide expert feedback from within their area of expertise.

Where concerns arise as a consequence of audit the assistant medical director will ensure the appropriate escalation to the medical director or the clinical effectiveness group as appropriate.

Service Line Clinical Governance Leads/Audit Leads/Education Supervisors
The Clinical Governance, Audit and Subject Expert Leads are responsible for the review and approval of clinical audit proposal forms and to liaise with the Deputy Audit, Assurance and Effectiveness Manager to ensure a forward clinical audit plan is agreed in line with Trust and Service Line priorities. In addition the Clinical Governance and Audit Leads are responsible for ensuring that the agreed plan of work is initiated and all evidence of participation, including results and recommendations are returned to the Clinical Audit Team.

Educational supervisors must ensure that clinical audit participation for revalidation, professional registration or as part of the education curriculum is undertaken in line with service line audit priorities.

Clinical Governance Leads must also ensure that audit activity, including the learning and actions taken as a result of participation, is reflected within the Service Line to Care Group Governance meeting and other required reports.

Care Group Management Team are responsible for seeking assurance that Priority 1 and 2 audits are completed, that appropriate action is taken in response to the conclusions and that learning is shared throughout and between the Care Groups where appropriate.
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Service Line Management Teams are responsible for:

- Approval of the service line's clinical audit plan and agreed clinical audit priorities
- Ensuring that Priority 1, 2 and 3 audits are completed, that appropriate action is taken in response to the conclusions and that learning is shared where appropriate.
- Ensuring presentation of audits/results
- Implementation of action plans and disseminating learning.

Clinical Effectiveness Group
The Trust has established the Clinical Effectiveness Group (CEG) to act as the lead forum for oversight of delivery of the Trust's effective care work stream. This group will:

- Review and agree the Clinical Audit Plan and monitor progress in delivery of the plan.
- Review audit results of significance to the Trust
- Ensure action plans are developed to address any arising areas of concern and monitor those action plans until they are complete.

All staff undertaking a clinical audit are responsible for:

- Registration of audits
- Ensuring the availability and security of casenotes
- Returning casenotes to the Central Records Library upon completion
- Presentation of audits results to an appropriate audience/meeting

5 Registration of audit activity

It is essential that all clinical audit and service evaluation activity is accurately recorded by the Clinical Audit Team. This allows the team to report our Trustwide position in regards to participation, learning and improvement as required.

The diagram in Appendix 1 can assist to establish the route that needs to be taken for the proposed activity.

Please note that the Clinical Audit Team is **not** responsible for research proposals and that these must be registered with the Research and Development Team.

Quality Improvement Projects should be registered with the Service Improvement Team.
It is essential that all clinical audit and service evaluation proposals are registered with the Clinical Audit Team. Although it is not recommended, the Clinical Audit Team can retrospectively register audits. The flow chart in Appendix 2 applies to both scenarios.

The Clinical Audit Team must also be informed of all national audit participation.

6 Audit priorities

Prior to the start of every financial year it is essential that all service lines set their audit priorities for the year and make appropriate arrangements to ensure that they are completed.

The priorities are:

Audit Priority	Summary	Example
Priority 1	External must do	National audit participation
Priority 2	Corporate must do	Clinical record keeping
Priority 3	Service Line must do	NICE guidance
Priority 4	Specialist Interest	----
Service Evaluation	----	----

It is expected that all service lines will participate in any relevant national audit commissioned by HQIP on behalf of NHS England.

It is essential that all service lines undertake the agreed corporate priorities in particular, clinical record keeping. This will ensure that the quality of the health record facilitates high quality treatment and care and that subsequently a health record can justify any decisions taken if required.

Service Line priority audits should be designed using NICE guidelines or a gold standard to determine compliance or to provide assurance.

7 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Trust Wide Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be approved by the Clinical Effectiveness Group and ratified by the Medical Director.

Non-significant amendments to this document may be made, under delegated authority from the Medical Director, by the nominated author. These must be ratified by the Medical Director and should be reported, retrospectively, to the Clinical Effectiveness Group.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust.

8 Overall Responsibility for the Document

The Medical Director or the Assistant Medical Director for Quality and Safety is responsible for ratifying this document. The Deputy Audit, Assurance and Effectiveness Manager has responsibility for the dissemination, implementation and review of this document.

9 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Trust Wide Documents.

The document author will be responsible for agreeing the training requirements associated with the newly ratified document with the named Medical Director and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

9 Monitoring Compliance and Effectiveness

Clinical Audit activity is monitored by the Audit, Assurance and Effectiveness Team and the outputs of this activity are reported as follows:

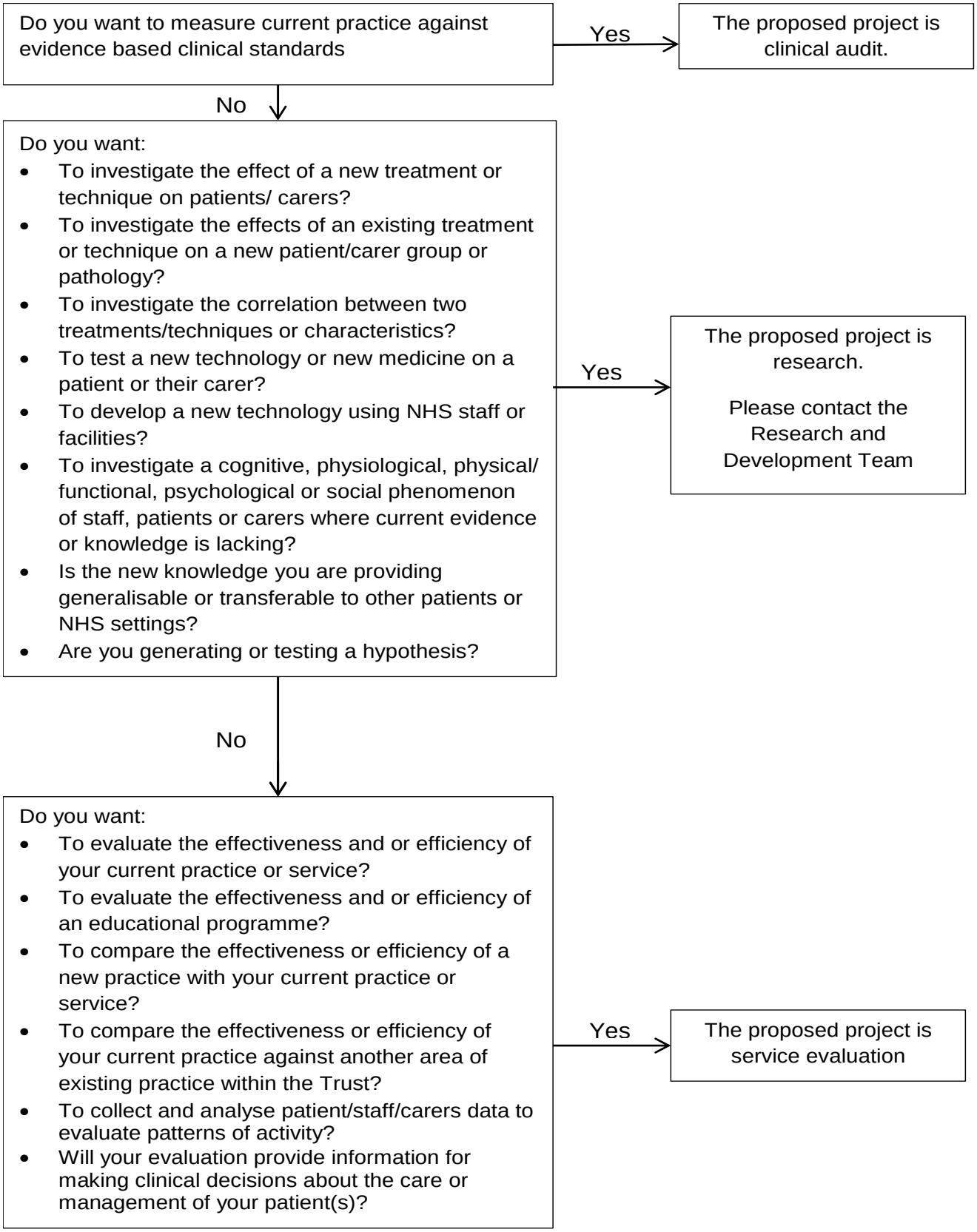
	Audit activity	**Frequency**
Quality Assurance Committee (QAC)	Clinical Effectiveness Topic Compliance Assessment	Annually
Clinical Effectiveness Group (CEG)	Clinical Audit Update	Three times per year

Safety and Quality Committee	Clinical Audit Update	Bi-monthly
Care Group Governance Meetings	Clinical Audit Update	Quarterly
Clinical Governance Lead Meetin	Clinical Audit Update	Six-monthly
Quality Account	Summary of all activity	Annually
NHS Improvement/Clinical Commissioning Group	Upon request	-
CQC	Routine Provider Information Request	Annually

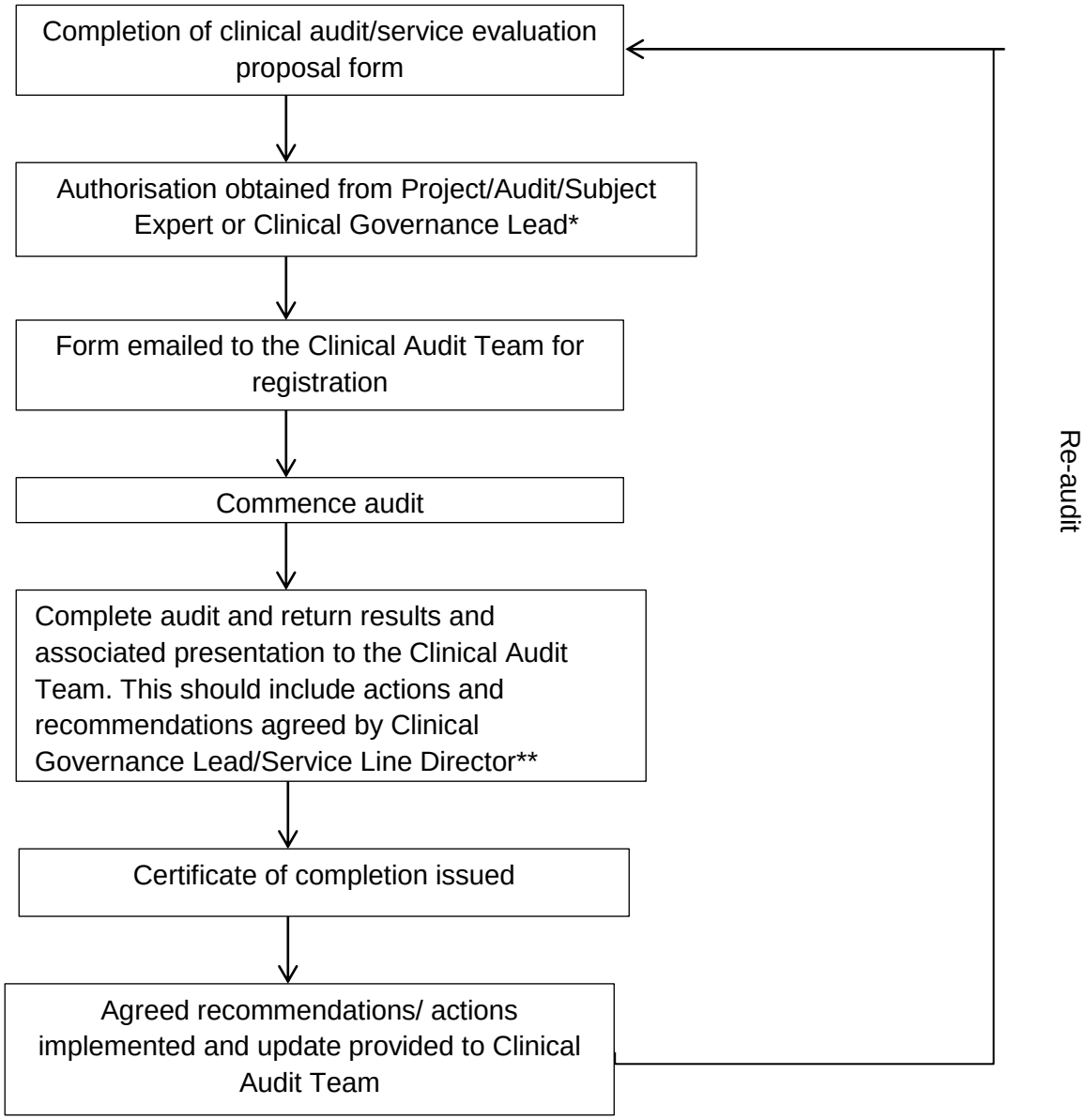
10 References and Associated Documentation

Regulation 10 of the Health and Social Care 2008 – Regulated Activities 2010 & 2014
NHS England – NHS Standard Contract
GMC – Good Medical Practice
GMC – The Trainee Doctor 2009
The Foundation Programme
NMC - The Code Professional standards of practice and behaviour for nurses and midwives

Proposal Decision Tree — Appendix 1



Audit Registration Process Flow Chart — Appendix 2



* The Assistant Medical Director for Quality and Safety will approve all clinical audit proposal forms in the absence of a suitable Clinical Governance, Audit or Subject Expert Lead, or where the proposed audit potentially has an impact on, or is linked to, a Trust priority or if the Clinical Audit Team feel that further clinical input is required.

** The Clinical Audit Team will oversee agreed actions and recommendations to ensure that they are implemented. The team will also record examples of learning.

Dissemination Plan and Review Checklist | Appendix 3

Dissemination Plan	
Document Title	Clinical Audit Policy
Date Finalised	May 2018
Previous Documents	
Action to retrieve old copies	Removal from StaffNET and additional communication through Vital Signs and Daily Email bulletin.

Dissemination Plan			
Recipient(s)	**When**	**How**	**Responsibility**
All Trust staff	July 2018	Vital Signs	Information Governance Team

Review Checklist		
Title	Is the title clear and unambiguous?	Yes
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Yes
	Does the style & format comply?	Yes
Rationale	Are reasons for development of the document stated?	Yes
Development Process	Is the method described in brief?	Yes
	Are people involved in the development identified?	Yes
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Yes
	Is there evidence of consultation with stakeholders and users?	Yes
Content	Is the objective of the document clear?	Yes
	Is the target population clear and unambiguous?	Yes
	Are the intended outcomes described?	Yes
	Are the statements clear and unambiguous?	Yes
Evidence Base	Is the type of evidence to support the document identified explicitly?	Yes
	Are key references cited and in full?	Yes
	Are supporting documents referenced?	Yes
Approval	Does the document identify which committee/group will review it?	Yes
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes
	Does the document identify which Executive Director will ratify it?	Yes
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Yes
	Does the plan include the necessary training/support to ensure compliance?	Yes
Document Control	Does the document identify where it will be held?	Yes
	Have archiving arrangements for superseded documents been addressed?	Yes
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes
	Is there a plan to review or audit compliance with the document?	Yes
Review Date	Is the review date identified?	Yes
	Is the frequency of review identified? If so is it acceptable?	Yes
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes

Equalities and Human Rights Impact Assessment | Appendix 4

Core Information	
Date	May 2018
Title	Clinical Audit Policy
What are the aims, objectives & projected outcomes?	This policy aims to promote a seamless, collaborative approach to clinical audit that will enhance the quality of care given to patients and be of significant benefit to all services. In addition this policy sets out the responsibilities for all Service Lines to ensure that the Trust has an effective Clinical Audit Programme that can demonstrate the delivery of patient-centred, high quality care that corresponds with national/local priorities and assessments.

Scope of the assessment
The Equality Impact Assessment (EIA) has been undertaken ensure that the publication of this policy is compliant with the Equalities Act 2010.

Collecting data	
Race	N/a
Religion	N/a
Disability	N/a
Sex	N/a
Gender Identity	N/a
Sexual Orientation	N/a
Age	N/a
Socio-Economic	N/a
Human Rights	N/a
What are the overall trends/patterns in the above data?	None
Specific issues and data gaps that may need to be addressed through consultation or further research	None

Involving and consulting stakeholders	
Internal involvement and consultation	Medical Director, Assistant Medical Director for Quality and Safety.
External involvement and consultation	
Impact Assessment	
Overall assessment and analysis of the evidence	

Action Plan

Action	Owner	Risks	Completion Date	Progress update