Essex Partnership University
NHS Foundation Trust

CLPG1 CLINICAL AUDIT PROCEDURE

PROCEDURE REFERENCE NUMBER	CLPG1
VERSION NUMBER	2.0
KEY CHANGES FROM PREVIOUS VERSION	Minor changes to audit process
AUTHOR	[redacted], Quality Governance Lead
CONSULTATION GROUPS	Clinical Governance & Quality Sub Committee
IMPLEMENTATION DATE	October 2017
AMENDMENT DATE(S)	
LAST REVIEW DATE	
NEXT REVIEW DATE	
CLINICAL GOVERNANCE AND QUALITY SUB-COMMITTEE RECOMMENDATION FOR APPROVAL	May 2021
APPROVAL BY QUALITY COMMITTEE	
COPYRIGHT	*Copyright © Essex Partnership University NHS Foundation Trust [date first published – date last published, e.g. 2017-2021]. All rights reserved. Not to be reproduced in whole or in part without the permission of Essex Partnership University NHS Foundation Trust.*

PROCEDURE SUMMARY

These procedural guidelines establish the governance arrangements and responsibilities for clinical audit in the Trust. This procedure provides a framework through which the clinical audit programme will be defined and delivered. It will ensure a consistency in the process across the Trust that is understood by all Trust staff and will clarify their individual responsibilities. This will ensure that the principles set out in the Clinical Audit Policy are translated into continuous clinical quality improvement

The Trust monitors the implementation of and compliance with this procedure in the following ways:

External Audit as scheduled

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this procedure is the Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CLINICAL AUDIT PROCEDURE

CONTENTS

This is an interactive contents page, by clicking on the titles below you will be taken to the section that you want.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROCEDURE FOR UNDERTAKING CLINICAL AUDIT

Assurance Statement

The purpose of these procedural guidelines is to establish the governance arrangements and responsibilities for clinical audit in the Trust. This procedure provides a framework through which the clinical audit programme will be defined and delivered. It will provide consistency in the process across the Trust, that is understood by all Trust staff and provide clarification on individual responsibilities. This is to ensure the principles set out in the Policy for undertaking Clinical Audit are translated into continuous clinical quality improvement

Equality and Diversity Statement

The Trust is committed to ensuring that equality, diversity, and inclusion is considered in our decisions, actions and processes. The Trust and all trust staff have a responsibility to ensure that they adhere to the Trust principles of equality, diversity, and inclusion in all activities. In drawing up this policy all aspects of equality, diversity, and inclusion have been considered to ensure that it does not disproportionately impact any individuals who have a protected characteristic as defined by the Equality Act 2010

1.0 INTRODUCTION

1.1 The following procedure and appendices sets out the process to register a project, gain approval, carry out and report on effective clinical audit in the trust. This procedure should be read in conjunction with the Trust policy on Clinical Audit (CLP1)

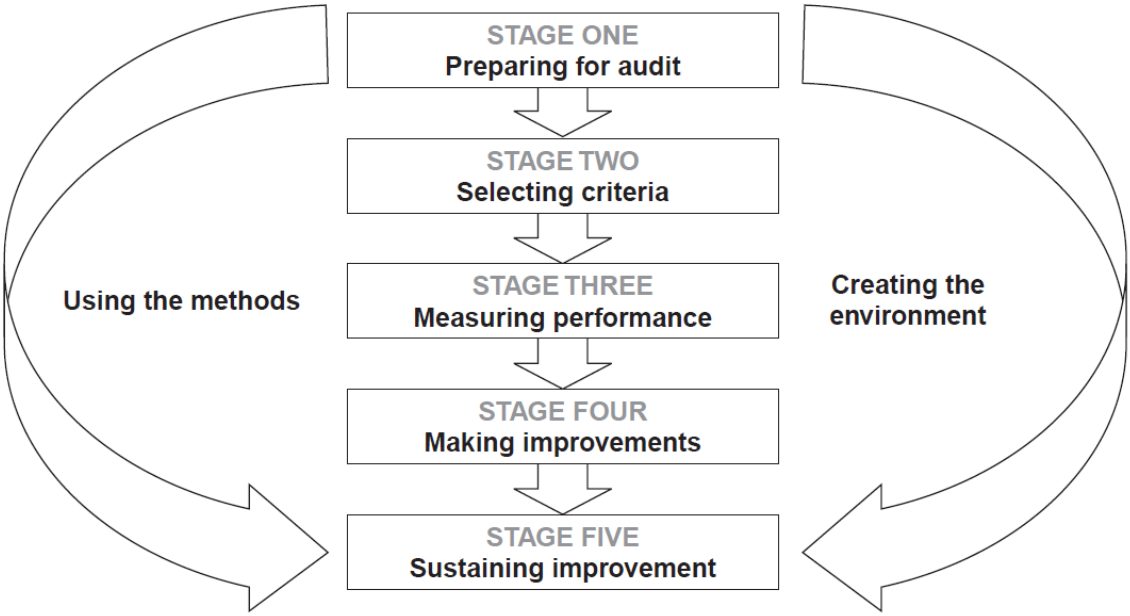
2.0 WHAT IS CLINICAL AUDIT?

2.1 Clinical audit is a systematic review that answers the question:
'Are we doing what we should be doing in the way we should be doing it'?

2.2 The clinical audit process:

- defines the context of the audit
- measures practice against agreed standards
- identifies any problems or deficits in compliance to those standards
- implements any changes in practice necessary to achieve the standards
- reviews, to measure whether practice has improved

Audit Life Cycle



Principles of Best Practice in Clinical Audit, NICE 2002

Stage one Preparing for an audit
This stage can involve asking the questions such as; what are we trying to achieve in terms of standards/clinical care? Does this task improve quality of care? Are we doing this right? Is this effective? Is this safe?

Stage two Selecting criteria
This stage looks at the criteria set against those questions and asks are we achieving what we set out to do. NICE guidance sets out best practice and can provide the criteria for audit. The Trust policies also set out the criteria for standards for providing clinical care. Before the test can be carried out the sample size must also be defined.

Stage three Measuring performance
Once criteria is set, the data collection begins. Depending on the test this could be over a period of time or looking for key information in records or even

Stage four Making improvements
Using action planning where shortfalls are identified

Stage five Sustaining improvements
Through monitoring and service development, with repeated clinical audit cycles as required

2.3 The Clinical Audit Department (CAD) is available to offer advice and support for clinical audit in the Trust Annual Clinical Audit Priority Programme

Types of Audit:

- National
- Trust priority
- Local

3.0 INVOLVING SERVICE USERS AND CARERS

3.1 Service users and carers often assess quality of care in different ways to healthcare professionals: they can provide a unique perspective based on their personal experience and can help design services around service user needs. Service users and carers should be involved in clinical audit where possible.

3.2 The Patient Advisory and Liaison Service should be contacted in the first instance as there may be able to provide links to networks as well as provide support and advice.

4.0 ETHICAL APPROVAL

4.1 Clinical audit proposals are not usually required to be submitted to a Research Ethics Committee. However, if there is any doubt, staff should seek the approval of the Trust's Research Governance Steering Group.

4.2 Further advice for audits involving service user interviews or questionnaires is available through the Patient Advisory and Liaison Service.

5.0 DATA PROTECTION

5.1 All clinical audit activity must take account of the General Data Protection Regulation (2018) and the Caldicott Principles (1997). This means that data used should be adequate, relevant, not excessive, accurate, and collected for the specific audit purposes only.

5.2 All Clinical audit activity needs to comply with the 'National Data Opt-out' that allows patients to opt out of their confidential patient information being used for research and planning purposes.

5.3 Data must be held securely in line with Trust policies and procedures for Information Governance; Records Management, Confidentiality and Records Management Storage & Retention. Operational project leads and the Clinical Audit Department must ensure any paper clinical audit data is held in a locked cupboard when not in use and all electronic data is password protected.

5.4 The patient's name and NHS number (which is considered patient identifiable) must not generally be used on raw data being used for data entry and analysis. Where it is necessary to know whom the data refers to, project leads must define a process to anonymise the case/s.

5.5 When projects are completed operational project leads must ensure paper based clinical audit data is sent securely to the clinical audit department to store securely.

5.6 The Records Management: NHS Code of Practice (2006) requires 'audit records' to be retained for a period of five years. This applies to clinical audit reports and results. However the Trust requires that all raw data should be destroyed as confidential waste as soon as the final report has been disseminated/ approved. See Records Management Policy CP9c Storage, retention and destruction of records procedure

6.0 DEVELOPMENT OF THE TRUST CLINICAL AUDIT ANNUAL PRIORITY PROGRAMME

6.1 An Annual Clinical Audit Priority Programme will be developed as priority work for the organisation with information sourced from the following:

- Relevant National Audits as advised by the Healthcare Quality Improvement Partnership (HQIP)
- Locality operational senior managers and service quality groups identified priority clinical audits
- Commissioner's requirements and Quality Accounts
- CQC Registration Standards
- NICE, National Enquiries, etc.
- Trust priority audits including themes arising from potential risks, complaints or serious incidents.

6.2 The Clinical Audit Department (CAD) will develop the draft annual clinical audit priority programme in consultation with the Directors, Associate Directors and Trust senior corporate and operational leaders. Agreeing any service specific audits in response to patient safety concerns in the service, providing assurance of the impact of any quality improvement work, as well as act on any risks identified in the operational areas.

6.3 A draft priority programme will be submitted to the Clinical Governance and Quality subcommittee (CG&Q) for approval and following this be presented to the Quality Committee for final approval and ratification.

6.4 CAD will focus on the delivery of this planned priority programme as its primary plan of work.

6.5 Each national or priority clinical audit will have an appointed clinical project lead, nominated by the Director responsible for services being audited when this is necessary.

6.6 Urgent projects identified by the Executive Team or from external bodies such as the Clinical Commissioning Groups (CCGs) during the financial year will be added to the priority programme and supported by CAD as required.

6.7 The programme will indicate the quality improvement workstreams the clinical audits support as well as note any associated national guidance.

7.0 PROCESS FOR THE CLINICAL AUDIT ANNUAL PRIORITY PROGRAMME

7.1 CAD will ensure all national and Trust priority clinical audit reports are disseminated to all relevant operational service quality and safety groups via their monthly clinical audit summary reports. The reports will provide information about the progress of the annual priority programme, escalate concerns should any projects not meeting timeframes, details of recommendations from relevant completed audits and details of any potential risks.

7.2 The Chairs of Quality and Safety groups will ensure progress with action plans are reported back, along with risks identified through the clinical audits as well as improvement initiatives are presented to their senior management teams (SMT) and CG&Q as necessary.

7.3 The CG&Q will receive bi-monthly reports and Learning Oversight Committee will receive quarterly reports provided by CAD. In this manner it is expected that learning from clinical audit, and clarity about outcomes, is shared through to all levels of Trust services.

7.4 CAD will provide reports to Performance and information as required for meetings with CCGs

7.5 CAD will complete an Annual Report on the activity with the programme for CG&Q and the Audit Committee.

7.6 CAD is responsible for maintaining a database of the audits carried out each year as part of the rolling programme of Clinical Audit. A report of the progress on the programme is provided to the CG&Q bi-monthly where issues with clinical audit projects or positive impacts are presented.

8.0 PROCESS FOR CARRYING OUT CLINICAL AUDIT ON THE PRIORITY PROGRAMME

8.1 Participation in the national audits, including those developed by the Prescribing Observatory for Mental Health (POMH) will use the nationally validated tools.

8.2 If required for the priority audit, audit tools will be developed via consultation between the project lead and the Clinical Audit Department project facilitator. These will use nationally agreed standards of practice and/or local Trust policies and procedures to inform development of criteria.

8.3 CAD will liaise with the national bodies/internal requesters regarding the requirements of the audits to be undertaken and communicate that information to the Executive Director, project lead/s and any other relevant persons/teams.

8.4 A pilot of the audit tool is required unless it is a validated tool i.e. developed by POMH or other national audit organisers, or has been previously used in the organisation.

8.5 CAD will work with the appointed clinical project lead to ensure the agreed audit tool is piloted when necessary to ensure it is fit for purpose and achieves identified aims i.e. will answer the areas under review. Implementing any necessary amendments required.

8.6 The project lead identified for the priority clinical audit will work with CAD to understand the parameters of the audit and agree a plan for managing the project. This may include:

- Timeframes and dates for project meetings to discuss data collection, data quality checking and submission, review of report, developing draft and final version of report and executive summary, developing actions plans with service leads and presenting to the relevant committees/groups.

- Coordinating data collection and quality checking the data, sourcing and appointing data co-ordinators and data collectors as necessary
- Agreement of where risks identified and the actions to be taken including escalation

8.4 Where agreed for the priority audit, completed data collection tools will be sent to CAD for collation, results preparation and analysis, with due care taken to protecting the data during transit in line with the Trust information governance policy and procedures.

8.5 The draft report will be the responsibility of the clinical project lead, using the clinical audit report template (Appendix 2), to complete this, ensuring any potential risks identified are action planned.

8.6 Where agreed for the priority audit, CAD will prepare a draft executive summary using Trust template (Appendix 1); including identifying any potential risks found in the audit. Once complete the summary will be shared with the clinical project lead/s who will work with the CAD to agree the recommendations and then progress to developing an action plan

8.7 Recommendations in clinical audit reports, in particular those related to the standards being audited, should be given a priority rating (high/medium/low).

8.8 Clinical Project Leads will discuss with the relevant services to formulate an action plan based on the recommendations from the completed audit. These actions:

- Should be SMART (Specific, Measurable, Achievable, Relevant and Time bound).
- Must detail who is taking responsibility for the action along with an expected completion date.
- Must be shared with the person taking responsibility for the action
- Are shared with relevant groups: these include Medicine Management Group, Medical Management Team, CG&Q and relevant operational service quality and safety groups.

8.9 If a re-audit is considered necessary, the action plan should identify a re-audit date. The re-audit timeframe should take into account timescales for agreed actions to be completed and the level of risk identified. For audits where a high level of compliance against the standard is provided, it may not be necessary to re-audit for 2 or 3 years.

8.10 The CG&Q will be responsible for monitoring implementation of action plans for national and priority clinical audits which CAD support via its bi monthly reports to the group.

8.11 Every national and priority clinical audit report is sent through to the relevant Executive Director for them or a nominated delegate for final approval prior to full dissemination of the report.

8.12 Final reports from the national and priority programme will be disseminated to CG&Q and all relevant operational quality and safety groups; to share learning from clinical audit activity and for wider sharing across the Trust.

8.13 Findings reports from the national and priority programme will be presented at appropriate Committee(s) / Group(s) e.g. Executive Team, Medicine Management Group as necessary. This will be identified as part of the action plan.

8.14 CAD will ensure final reports for all national and priority clinical audits are uploaded onto the Trust's intranet and as required any publications supported by the Nursing and Quality Directorate such as Quality Matters, 5 Key Messages or Learning Bulletin. In this way the Trust seeks to share learning from clinical audit with the widest possible population of staff.

8.16 Clinical teams will be responsible for making any necessary changes or improvements to practice as a result of the audit, and this should be monitored by the relevant operational quality and safety groups. CAD will support this by monitoring and regularly reporting into these groups on the completion of action plans identified for all national and priority clinical audit reports pertaining to those services relevant to that group.

8.17 Unless otherwise indicated by the audit lead, audits will be scored as follows:

- Above 90% - Green - Compliant
- 75%-90% - Amber - Improvement needed
- Less than 75% - in red - no robust systems evidenced by audit; action plan required.

8.18 In addition to the annual programme overseen by CAD, clinical audit activity is undertaken by Safeguarding, Mental Health Act Team, Medicines Management Group and Infection Control to meet Trust requirements. These are overseen and managed by the Head of Safeguarding, Associate Director for Professional Development, Chief Pharmacist, and the specialist team for Infection Prevention and Control who will decide scope, frequency and provision of reports as required.

8.19 CAD will issue audit certificates for persons who have met all the criteria they need to when taking part in national audits.

9.0 PROCESS FOR LOCAL CLINICAL AUDITS AND SERVICE EVALUATIONS

9.1 Individuals who wish to carry out an audit should approach the CAD in the first instance to discuss their proposal. Individuals will be encouraged to support the priority programme and will be given the necessary information by CAD.

9.2 A project proposal form (Appendix 3) must be completed and this can be obtained from them or from the Intranet.

9.3 Proposals should include information about trust policies, procedures, national guidance, current or emerging risks/issues, or previous audits that the proposed audit refers to and what standards or criteria or process are being tested. Where possible, an initial draft of the proposal should be discussed with CAD.

9.4 A draft audit tool should be developed to support the audit proposal. Ideally this would be a previous tool used within the Trust, or a local adaptation of a nationally validated tool such as POMH or NICE audit criteria. If these are not appropriate then a newly developed draft tool can be developed. The project

proposal and proposed tool must then be presented by the clinical project lead to MMG or practice supervisor for approval.

9.5 Proposals for local audits will require approval from an audit/practice supervisor. This can be a Lead Consultant, Consultant Psychiatrist, Clinical Supervisor or Clinical Director as described in the policy under duties.

9.6 Audit/Practice Supervisors should be aware of their responsibility to supervise audits undertaken within their areas, given the amount of time spent on the audit and the effect this could have on the service as mentioned in the policy under duties.

9.7 Clinical audit proposals relating to medications will require approval from the Medicines Management Group (MMG) as well. The proposal must be presented to the group along with the audit tool to be used

9.8 Proposals for clinical audit or service evaluations involving patient questionnaires or interviews will need to evidence they have sought guidance from the PALS service.

9.9 Evidence of approval (including evidence of PALS if required) to be forwarded with the completed proposal form and audit tool to the Clinical Audit Department for registration. Evidence of approval can be via minutes, signed document or e-mail. The paperwork will be checked and audit registered with CAD.

9.10 The project lead must also provide timeframes for data collection, analysis, report generation and presentation. CAD will provide details of dates for presenting to the relevant forums such as quality and safety groups, MMG etc.

9.11 Data collection should take place within the identified timeframes stipulated within the project proposal as it is important that local clinical audits are carried out within an acceptable time frame to enable results to inform current practice.

9.12 The project lead should inform CAD and Audit/Practice Supervisor if any issues arise in the project. CAD will aim to support in resolving the issues as much as possible.

9.13 The project lead will produce a clinical audit report (Appendix 2) or slide set; ensuring an action plan is developed via discussion of the results with clinical and other colleagues as appropriate. The findings should be forwarded to the CAD with the SMART action plan at the earliest opportunity.

9.14 The project lead must, as a minimum, present the clinical audit report to their practice area and peers. Ideally this would be via presentation at the Local Quality and Safety groups. However, it is also important to share the audit findings and outcomes with any relevant teams and committees as identified including other teams and services that the results could affect. CAD will support this by sending out local reports to other relevant operational service quality groups for their information if this is identified with the project lead.

9.15 Clinical teams will be responsible for making any necessary changes or improvements to practice, and this should be monitored by the relevant operational service quality group.

9.16 The CAD will keep a log of all local clinical audit projects undertaken in the Trust. Encouraging the completion of audits, in particular the preparation and presentation to colleagues of the findings is important. Presentations and reports will highlight any identified potential risks and an achievable action plan.

9.17 CAD will issue audit certificates for persons who have met all the criteria they need to when taking part in local audits.

9.18 Clinical audit projects should be completed within 12 months of registration after which it will be withdrawn, notification will be sent to the approver and no further reminders will be sent by CAD.

END