Essex Partnership University
NHS Foundation Trust

CLPG1 – Clinical Audit – Appendix 3

This form registers your project and should detail how it will be carried out. You will need to have the appropriate approval (see flow chart) prior to undertaking the audit.

The Clinical Audit Department can provide information and advice with developing a local project, please ask.

IF POSSIBLE, PLEASE TYPE AND E MAIL TO THE CLINICAL AUDIT DEPT AS APPROPRIATE

Project Title:	**Audit Project No:** (For CAD use once project has been approved)

AUDIT LEAD (Clinical lead person for the project)

Name:	**Designation:**	**Lead Consultant**
Service: **Contact Telephone No:**	**Base:**	
Proposal Approved by:		
Medicines Management Group (MH or CHS) **(All medicines related Audits must go via this route)**	**Sign or by Minutes/ e-mail**	**Date**
or		
Operational Quality & Safety Group	**Sign or by Minutes/ e-mail**	**Date**
or		
Clinical /Practise Supervisor	**Sign or by e-mail**	**Date**

STANDARDS INFORMING THIS AUDIT COME FROM: PLEASE TICK/STATE

☐ National Audit ☐ Commissioner's Requirement ☐ NICE ☐ RMS/Compliance

☐ Registration Standards ☐ Trust Policies/Procedures ☐ CHS ☐ Other Standards

Please State the standard(s) used here:

Please tick Service/s to be audited below:

Adult MH ☐ OPMH ☐ Forensic ☐ CAMHS ☐ LD ☐ CHS ☐ Other *(Please specify)* _____

Inpatient ☐

Community ☐

Please indicate which Service area(s) are being audited (i.e. Teams / Wards):

OVERVIEW : (Description of project; reason for choosing it; sample size; who will collect data; method of data collection; what you hope to achieve as an outcome)

Please tick to agree the following:

To protect the security of all data (paper & electronic) ☐

To pilot the audit tool, if required ☐

To ensure report is written including agreed action plan to agreed timescale ☐

To present the results at a suitable forum (e.g. Medical Education, Medicines Management Group or Operational Quality & Safety Group) ☐

PARTICIPANTS (From within your service and other services e.g. Colleagues, staff from other disciplines/teams, other service providers)

SERVICE USERS INVOLVEMENT (Please describe if service users are involved in this project) Service Users should, wherever possible, be involved in the design and carrying out of an audit project. Detail any involvement in this particular project.

Proposed start date for project (after approval has been gained) ☐

Expected completion date (written report & Action plan available) ☐

When completed please return to Clinical Audit Department at:

Trust Head Office
Third Floor, The Lodge
Lodge Approach
The Chase, Wickford
SS11 7XX
Tel: [redacted]
Or email [redacted]

FOR CLINICAL AUDIT DEPARTMENT USE ONLY

Proposal Received by Clinical Audit Team:	**Date:**
Approved by Operational Quality & Safety Group *(via meeting minutes)*	**Date:**

LOCAL CLINICAL AUDIT

Flow chart for Approval and Registering of Local audits