POLICY DOCUMENT

Burton Hospitals
NHS Foundation Trust

CLINICAL AUDIT POLICY

Approved by:	**Executive Management Team**
On:	**16 June 2015**
Review Date:	**June 2018**
Corporate / Directorate	**Corporate**
Clinical / Non Clinical	**Non Clinical**
Department Responsible for Review:	**Governance**
Distribution:	
• Essential Reading for:	**All Clinical Staff** **Divisional Medical Directors** **Clinical Audit Leads** **Executive Directors** **Senior Managers**
• Information for:	**All Clinical Staff**
Policy Number:	**122**
Version Number:	**3**
Signature:	**Chief Executive**
Date:	**16 June 2015**

Burton Hospitals NHS Foundation Trust

POLICY INDEX SHEET

Title:	**Clinical Audit Policy**
Original Issue Date:	**July 2008**
Date of Last Review:	**June 2015**
Reason for amendment:	**Scheduled review, revised governance arrangements, revised priority of audit plans.**
Responsibility:	**Head of Compliance**
Stored:	**Intranet**
Linked Trust Policies:	**Best Practice Policy** **Health Record Keeping Policy** **Incident and serious incident management policy and process** **Confidentiality Policy** **Information Governance** **Communication Strategy**
E & D Impact assessed	**EIA 118**
Consulted	**Executive Management Committee** **Divisional Medical Directors** **Associate Directors** **Clinical Audit Leads** **Head of Governance and Risk** **Divisional Governance Managers** **Research and Development Manager** **Head of Corporate Affairs**

REVIEW AND AMENDMENT LOG

Version	Type of change	Date	Description of Change
3	Review & Update	June 2015	Scheduled review, revised governance arrangements, revised priority of audit plans.

CLINICAL AUDIT POLICY

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Burton Hospitals NHS Foundation Trust

CLINICAL AUDIT POLICY

1. BACKGROUND

1.1 "All doctors employed in or under contract to the NHS will, as a condition of contract, be required to participate in annual appraisal, and clinical audit, from 2001."[1] It is our principle that all health professionals, not just medical staff, should engage in reflective practice, clinical audit. The Trust is committed to providing an environment and structure that support clinicians in these activities, to promote best practice and effect improvements in patient care.

1.2 Regular review of practice in NHS Trusts is a requirement of the Department of Health and evidence for this impacts on evaluation of Trusts under the Care Quality Commission's inspection processes [2]

1.3 Specific requirements are associated with NICE guidelines and National Service Frameworks. The implementation of NICE Technology Appraisals is a statutory requirement, and clinical audit provides part of the evidence for this, along with policies and patient surveys.

1.4 Medical staff have a professional requirement to conduct regular clinical audit.

1.5 Increasingly, Trust participation in national audits is required or encouraged. Projects approved by the National Clinical Audit and Patient Outcomes Programme (NCAPOP), and those for inclusion in the Quality Account, that are relevant to Trust services require participation. The Trust needs to ensure that it has robust systems in place to support them.

2. POLICY OBJECTIVE

2.1 The objectives of the policy are to define and describe the requirements for clinical audit, as well as the processes needed to effect it. This is done with the intention of developing and sustaining a culture of best practice and learning within the Trust and in the context of the wider health economy.

3. SCOPE OF THE POLICY

3.1 The Trust must have in place effective governance, including assurance and auditing systems or processes, as part of meeting the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A). Clinical audit should be structured and supported to maximise the quality of results against the time and effort expended.

3.2 The policy defines and describes the Trust's systems for supporting these requirements.

4. DEFINITION

4.1 NICE defines clinical audit as "*a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure,*

processes and outcomes of care are selected and systematically evaluated against explicit criteria ".[3]

5. DUTIES/ROLES AND RESPONSIBILITIES

5.1 Chief Executive

The Chief Executive has overall responsibility for ensuring that the organisation has a robust structure for clinical audit that delivers quality of care commensurate with best current clinical evidence.

5.2 Medical Director

The Director of Governance has Board level responsibility for Clinical Audit and is responsible for managing the Head of Compliance and for monitoring clinical audit against CQC requirements. The Medical Director has responsibility for overseeing consultant engagement in clinical audit activity and for ensuring that clinical directorates respond to national clinical audit findings and external reviews, including confidential enquiries.

5.3 Head of Compliance

5.3.1 The Head of Compliance is responsible for overseeing and facilitating the development of clinical audit programmes and for maintaining information systems to monitor progress, support change and provide evidence of quality improvement. They will also:

- Produce a comprehensive Annual Report
- Co-ordinate the annual Clinical Audit Programme
- Report to the Clinical Audit and Effectiveness Committee
- Delegate a Local Reporter for NCEPOD
- Monitor progress against the audit programme
- Provide training in clinical audit and critical appraisal and provide advice on methodology
- Establish and maintain links with the wider health economy
- Act as the Trust co-ordinator for national audits, and in conjunction with the Research and Development Manager, as the Trust gatekeeper to ensure that research is not done under the guise of audit
- Maintain and encourage communication with the Caldicott Guardian as appropriate

5.4 Clinical Audit Leads

5.4.1 Each specialty or clinical department will appoint a Clinical Audit Lead. The duties of the Clinical Audit Lead are detailed in the Trust document "Best Practice for Clinical Audit Leads"[4], but broadly encompass the following:

- With the Head of Compliance or nominated senior auditor, develop a clinical audit programme for the specialty / department, in collaboration with colleagues and managers for their area and monitor progress against it
- Allocate audit topics and assign a priority to each audit
- Provide advice and support to clinicians undertaking audits
- Be co-responsible for approving proposed audits and ensure that all audits under their control are registered
- Co-ordinate clinical audit meetings for their area and provide time for presentation and dissemination of audit findings

- Inform the Clinical Audit and Effectiveness Department of completion of audits
- Liaise with audit supervisors to ensure the completion of audit actions resulting from audit findings and requirements for re-audit
- Provide evidence of their specialty / department's engagement in audit activity and changes resulting from it

5.5 Clinical Audit Supervisors

5.5.1 Clinical Audit Supervisors will usually be consultants or other senior clinical staff with specialist interest in the subject under audit. They will have overall responsibility for directing the audit, and will be specifically responsible for the following:

- Co-approving audit proposals with their Clinical Audit Lead
- Monitoring progress of audits under their supervision
- Providing mentorship to staff conducting the audit
- Agreeing time for presentation and discussion with their Clinical Audit Lead
- Ensuring that the Trust, through the Clinical Audit and Effectiveness Department, is provided with a copy of the final report or presentation of the audit
- Approving audit certificate applications appropriately
- Completing and returning information to the Clinical Audit and Effectiveness Department, about the completion of audit action and provide details of changes resulting from audit findings and requirements for re-audit.

5.6 Quality Committee and Audit Committee

The Quality Committee is responsible for approving the Annual Audit Programme and the Clinical Audit and Effectiveness Annual Report. The Annual Audit Programme will then be presented to the Audit Committee for information. The Quality Committee will receive regular updates on progress against the Annual Programme via the Clinical Audit and Effectiveness Committee.

5.7 Clinical Audit and Effectiveness Committee

The Clinical Audit and Effectiveness Committee will receive regular periodic reports from the Clinical Audit and Effectiveness Department and will follow up areas of concern. The Clinical Audit and Effectiveness Committee will monitor progress against actions arising from internal and external reports and audits and ensure that clinical standards eg those from NICE are formally received, reviewed, allocated a lead and that action is taken appropriately and implementation is robust.

5.8 Divisional performance review meetings

The Divisional performance meetings will receive information each quarter detailing the division's progress with the delivery of their clinical audit programme, and compliance with national confidential enquiries and/or action plans relating to National Reports. The divisional performance meetings can escalate items to the Clinical Management Committee, the Executive Management Committee or the Clinical Audit and Effectiveness Committee as appropriate.

5.9 **Staff undertaking clinical audits**

All staff undertaking audits will abide by the terms of this policy.

6. THE ANNUAL CLINICAL AUDIT PROGRAMME

6.1 Clinical Audit will be delivered as a structured programme of audit projects/activity. The Clinical Audit Programme for any given financial year will be formulated in the following manner:

The Head of Compliance will write to Clinical Audit Leads, Associate Directors of Surgery, Community and Medicine, Divisional Medical Directors and Clinical Directors, in December of the preceding year requesting that Directorates begin to consider their local audit programmes and priorities.
They will be asked to consult with colleagues to ensure that all specialists have the opportunity to voice their opinions on priorities for the programme. This consultation will include discussions with the Divisional Governance Leads to ensure that the audit programme takes complaints, incidents and the risk register into account. They will also be asked to ensure that both internal and external drivers are considered when planning their programmes, to include NICE guidelines, NSF and NCEPOD recommendations, and any locally-identified risk that has not been assessed.

6.2 The Clinical Audit team will provide the Clinical Audit Leads with audit templates for each specialty as appropriate, which will be partially populated with audits that will be carried forward to the following year (including those that are under way) and any audits that have been scheduled to be repeated in that year. Known high priority projects, such as documentation audits, will be included automatically where they are known.

6.3 It is understood and acknowledged that the Clinical Audit Programme is a living document, and that requirements for audits might change during the course of the year. This might be because service delivery changes or because new evidence or guidelines are published, or because the information needed for an audit is provided by another audit. The Associate Director and/or the Divisional Medical Director will be asked to approve audits that are proposed after the start of the financial year, to ensure that the Division has sufficient resources to deliver all of the audits in their forward plan. The Trust aims to ensure that all audits undertaken within its boundaries are identified and recognised, and that no audits are conducted without its knowledge.

6.4 The Clinical Audit Programme will mainly include clinical audits, both local and national, and only on an exception basis clinical monitoring projects or service reviews, where there is a clear audit standard and robust audit methodology is used.

7. PRIORITISATION OF LOCAL AUDITS

7.1 Every audit will be allocated a priority according to the judgement of the Clinical Audit Lead approving it. Priority will be defined as:

- **High** - High priority audits are those which have, as their driver, identified gaps in compliance with guidelines, e.g. audits against NICE guidelines; or which are prompted by risks to the Trust, e.g. audits identified by critical

incidents, complaints or litigation and audits that address NICE Quality Standards

- **Routine -** Routine audits may be prompted by changes in practice, either expected or accomplished, eg audits against newly-published guidelines and re-audits. They will also cover those for which no specific prompt has been identified, but which may demonstrate good practice or help uncover weaknesses. Many of these projects will have been prompted by staff observations of clinical practice.

7.2 All audits will be conducted with the express purpose of identifying quality of practice to encourage continual improvement to patient care.

7.3 Audit completion and evidence of consequent actions will be monitored rigorously where audits are prioritised as high.

8. PARTICIPATION IN NATIONAL AUDITS

In February 2008 the Department of Health announced a new structure for management of national audits, and National audits are increasing in number, size and complexity. The Trust will undertake to participate in all national audits that are included in the NHS Standard Contract, and as such are included in the list provided by NCAPOP and, those requiring reporting in the Quality Accounts, provided they are relevant to the services provide by the Trust. All such national audits will be classed as **"critical priority",** and will take priority over local audits, in terms of the resources of the Clinical Audit and Effectiveness Department.

9. INTERFACE AND REGIONAL AUDITS

Projects undertaken in collaboration with other members of the health economy, including commissioners, will be registered by all participating organisations, and this will be done regardless of the instigating organisation. Approval for such projects will be required by all parties concerned and project methods will be agreed prior to commencement of data collection. Caldicott approval should be sought to ensure probity of use of data, and results will be made available to all organisations taking part.

10. THE CLINICAL AUDIT DATABASE

A database will be administrated by the Clinical Audit and Effectiveness Department. The database allows authorised staff to register all audits. It will include information to provide the Trust with relevant evidence to support its objectives. The database will also function as an archive and resource, so that clinicians undertaking audits in the future can assess findings against previous audits and evaluate effectiveness of actions. The database will be subject to continuous updating by all relevant Trust staff.

11. AUDIT PROCESS

11.1 REGISTRATION

11.1.1 Every clinical audit will be registered. Registration is achieved by submission of a completed project proposal form, which can be found on the intranet. The Clinical Audit and Effectiveness Department will accept a proposal for registering on the database only if it bears the signatures of the appropriate Clinical Audit Lead and audit supervisor. Every project must be proposed by the supervisor and approved by the appropriate Clinical Lead prior to commencement of data collection. Any registration that has been received in the Clinical Audit and Effectiveness Department without the appropriate signatures will be sent to the Clinical Audit Lead and/or audit supervisor for signature.

11.1.2 Registration forms MUST BE APPROVED BY THE CLINICAL AUDIT LEAD. The purpose of this is to ensure that Clinical Audit Leads are fully equipped to monitor audit activity in their own area. The signature provides assurance to the Clinical Audit Manager and the Trust that the audit is clinically viable and appropriate.

11.1.3 Audit proposal forms must also bear the signature of the audit supervisor. The Clinical Audit Lead and the audit supervisor will, in some cases, be one and the same person, who should sign for both roles on the form. The responsibilities to which these parties agree is stated under the signature lines on the proposal form. A copy of the proposal form may be found in Appendix A.

11.2 **Audit Standards**

11.2.1 The organisation is committed to driving up quality by various means, and not solely through clinical audit, although this will be the main focus of the Clinical Audit and Effectiveness Department. Project proposals will be categorised as:

- Clinical Audit
- Service Evaluation (where there is clear audit standards and methodology)
- Survey (where there is clear audit standards and methodology)
- Benchmarking (where there is clear audit standards and methodology)

11.2.2 Where a project is determined to be a clinical audit, it will be required to satisfy the methods associated with good clinical audit, one of which is that the tool used to measure practice will accurately reflect the standards being audited.

11.2.3 **Audit tools** will show clear association with the aims and objectives of the audit as defined on the proposal form. Tools may be developed or acquired. Sources of acquisition would include:

- Previously tested audit tools, especially for re-audit
- NICE audit tools
- NCEPOD audit tools
- Scaled-down versions of national data sets

Where new tools are developed, they will be reviewed and approved by the audit supervisor(s) and/or the Clinical Audit and Effectiveness Department. Previously untried audit tools should be subjected to a pilot phase to improve validity.

11.3 Presentation and dissemination of audit findings

11.3.1 Audits should be presented as soon as possible after completion. The forum for presentation should be the most suitable for the audit findings, in many instances the designated audit meeting for the specialty or department will be the forum, but other departmental meetings can also be utilised. It is the responsibility of the Clinical Audit Lead to allocate time for the presentation of audit results, and ensure that there is no delay in the presentation of the results. In many cases, audit findings will be of relevance to other disciplines and professions and, where possible, relevant staff from other areas should be invited to attend meetings. Where this is not possible, audit results will be disseminated to relevant departments or staff for consideration and action as appropriate. Auditing should be multidisciplinary by nature, and all grades and professions should be included in auditing and attendance at meetings.

11.3.2 A template for producing audit presentations is available on the Trust intranet on the Clinical Effectiveness & Audit site and is contained herein as Appendix B.

11.3.3 Audit results should be discussed fully at the time of presentation and draft action plans agreed. Monitoring of actions will take place by through the divisional audit action plan.

11.3.4 Following presentation and discussion of an audit, the Clinical Audit and Effectiveness Department should be informed and a copy of the presentation or report sent to them. Departments should keep records of their own audit meeting attendance.

11.4 Audit certificates

11.4.1 On completion of an audit, those involved in the project may apply for a certificate acknowledging their work. The certificate application form is available on the intranet or on request from the Clinical Audit and Effectiveness Department. In order to qualify for a certificate, auditors must have completed and presented the audit, and provided the Clinical Audit and Effectiveness Department with a copy of their presentation.

11.4.2 The certificate application form should be completed and submitted to the relevant audit supervisor for authorisation. It is the responsibility of the auditor to submit the authorised form to the Clinical Audit and Effectiveness Department, who will issue a certificate, provided:

- The audit has been properly registered, and
- A copy of the final report or presentation has been submitted to the Clinical Audit and Effectiveness Department

Except where circumstances have prevented presentation of the audit prior to the departure of the auditors, it will also be expected that the audit will have been presented and discussed in an appropriate forum before a certificate will be issued.

11.4.3 Where staff have undertaken work relating to a national audit, this will be stated on the certificate. Where staff have presented audit findings at trust-wide functions, e.g. Educational Half Days, this will be stated on the certificate.

11.5 Change and improvement

11.5.1 Change can be effected only with the co-operation of enabled participants in practice. Audit reports will be made available at clinical audit meetings, and will also be accessible through the Trust's intranet site by keyword search.

11.5.2 **Action plans** will be agreed and change promoted through communication (reports, emails, action plans and meetings). Barriers to change will be identified and recorded on the audit action plan, so that they can be addressed.

11.5.3 Improvements may be brought about by various methods, including education, reviews of and amendments to guidelines and practice, improvements in documentation, better communication and changes in clinical or administrative practice. Full re-audit is not necessarily required to monitor the effect of changes and the Plan, Do, Study, Act (PDSA) cycle may be a more appropriate way to monitor the effects of actions, at least in the short term. Targeted re-audit may be used where specific aspects of care have been addressed or modified.

11.5.4 Where actions are necessary to address adverse findings, but cannot for any reason be carried out at ward, specialty or department level, the findings and recommendations will be reported to the appropriate directorate, Clinical Audit and Effectiveness Committee, who will determine any need for further mitigation of risk or further escalation.

11.6 RECORDING AND MONITORING ACTIONS

11.6.1 There is little point in collecting and presenting data unless change and improvement can result. Each Division will hold a Clinical Audit Action Plan. This action plan should be reviewed through the Divisions Governance arrangements, and the progress with the delivery of the actions will be discussed each quarter at the Clinical Audit and Effectiveness meetings. When all of the audit actions are complete, the audit should be signed off as complete by the supervisor.

11.6.2 Recommendations made and actions agreed at the time of presentation will be entered on the audit action plan within a week of the presentation, by the by the audit supervisor or Clinical Audit Lead, as appropriate. If there are barriers to implementation, or any part of the action plan is outstanding at the time, an explanation of failure to implement the action, or an expected date for completion, will be recorded on the action plan. Updates should be recorded as appropriate.

11.6.3 The Clinical Audit Lead will provide the Clinical Audit and Effectiveness Department with a copy of the up to date audit action plan, each quarter.

11.6.4 If a previously unrecognised risk is identified from the results of an audit, and immediate action cannot satisfactorily mitigate that risk, it should be recorded on the appropriate Risk Register, in line with the Trust's risk management process. Audit supervisors should liaise with one of the Divisional Governance Leads to ensure that this is done.

12. REPORTING

12.1 The Clinical Audit Leads will provide the Clinical Audit and Effectiveness Department with an up to date version of their departments audit action plan each quarter. The Clinical Audit and Effectiveness Department will use this information together with the information held within the audit database, to prepare a quarterly progress report on audit delivery for each division. This information will be provided to Clinical Audit Leads, Associate Directors, Divisional Medical Directors and Clinical Directors, and the Director of Governance for tabling at the Divisional Governance meeting once a quarter

12.2 The Head of Compliance, will provide quarterly reports to the Clinical Audit and Effectiveness Committee summarising the progress in the delivery of the annual audit programme, and information about of local audits demonstrating excellent practice, improved practice or a need for remedial action (with materiality judged by relative risk). Actions taken against recommendations will also be reported.[8]

12.3 Recommendations from national audits and external reviews will be addressed by the procedures described in the Best Practice Policy[6]. Any risks identified from these audits and reviews will be reported first to Divisional governance groups and, if necessary, escalated to the Clinical Audit and Effectiveness.

13. INFORMATION GOVERNANCE

13.1 **Use and retention of data**

13.1.1 All staff undertaking clinical audit must be conscious of the need to maintain confidentiality at all times. Wherever possible, data collection should be anonymous. If necessary, hospital identification numbers may be recorded but under the following conditions:

- They must not be stored on portable data storage devices unless those devices are encrypted
- Any such data must be destroyed at the earliest opportunity
- It is the responsibility of the auditing clinician(s) to protect confidentiality of patients and/or carers

13.1.2 Express consent by patients that their information be used in audits is not required, but the hospital information booklet includes a paragraph that explains clinical audit and allows patients to opt out.

13.1.3 Patient identifiable data must not, on any account, be transferred to any party or organisation outside the Trust for the purpose of clinical audit unless:

- It has been encrypted or
- It has been transferred from one nhs.net account to another
- There is express understanding on the part of the Trust that this will be done as, for example, in the case of NCEPOD

13.1.4 The Clinical Audit and Effectiveness Department has procedures in place to monitor the patient data held locally and to ensure destruction of such data at an appropriate time.

13.1.5 The Clinical Audit Proposal Form requires details of compliance with Information Governance.

13.2 **Patient Records**

13.2.1 For audits that require review of paper records, the Clinical Audit and Effectiveness Department will request notes.[9] A form to facilitate requests for patient lists or clinical notes can be found on the intranet.

14. SERVICES PROVIDED BY THE CLINICAL AUDIT AND EFFECTIVENESS DEPARTMENT

14.1 The Clinical Audit and Effectiveness Department will support and advise clinicians undertaking audits, regardless of their profession or grade. This support and advice will be provided according to need, and the availability of resources within the Department, and will take the form of:

- Assistance with locating guidelines, where the clinician has tried and been unsuccessful
- Assistance with identification of appropriate cases for audit
- Assistance with questionnaire design
- Assistance with data analysis (presence of the auditor during this process is strongly encouraged)
- Assistance with report or presentation preparation, although the responsibly for the preparation remains with the auditor
- Training in clinical audit principles and methods
- Advice on scientific and statistical validity of audits
- Assistance with retrieval of notes

14.2 The ultimate aim is to support clinicians to become competent to undertake and complete clinical audits independently. Staff should contact the Department to arrange an appointment using extensions 5418 or 5723, or by email.

14.3 The Clinical Audit and Effectiveness Department will produce reports on a quarterly basis, giving information on progress against the audit programme to Clinical Audit Leads and Medical Directors. These reports will be used by the Medical Directorates to help them monitor and manage their programmes.

14.4 **TRAINING**

14.4.1 Training will be available to any clinician wishing to undertake clinical audit, regardless of profession or grade. Staff wishing to attend training should contact the Clinical Audit and Effectiveness Department. Specialties or departments may request training for their staff, which will be organised as and when required. The availability of training will be dependent upon the availability of resources within the Clinical Audit and Effectiveness Department, and training materials and a workbook are readily available on the Trust intranet site.

14.4.2 Specific training for junior doctors, to incorporate assessed activities, will cover every aspect of clinical audit and the audit cycle.

15. THE AUDIT/RESEARCH REVIEW GROUP

15.1 The Trust has a review group that has a remit to review any projects identified by the Head of Compliance and the Research and Development Manager as being potentially research and not audit, service evaluation or survey. This group will meet *ad hoc* when any such project requires review, and will refer

to the local research ethics committee where necessary. Review of projects by the group will be a standing item on the agendas of both the R&D Committee. This ensures that the Trust does not contravene the Research Governance Framework.

16. PATIENT AND PUBLIC INVOLVEMENT

16.1 Patients are encouraged to become involved in the clinical audit process, bringing their knowledge and experience to the planning and execution of audits. Patients and carers will be given the opportunity to suggest topics for audit and to advise on methodology where appropriate.[10]

16.2 Patient/public surveys are valuable sources of information to improve patient care. Overall responsibility for patient and public surveys lies with the Patient & Public Engagement, team, but assistance in designing and executing surveys can be provided when necessary by Clinical Audit staff on request.

16.3 The Clinical Audit and Effectiveness Department will endeavour to provide the Patient and Public Engagement Advisor with any information relating to patient and public opinion that comes into its sphere.

17. INTEGRATED GOVERNANCE

17.1 The Trust has adopted an integrated approach to Governance. The Head of Compliance will liaise with the Head of Governance and Risk, the Head of Health and Safety, Complaints & PALS Manager, Patient and Public Engagement Advisor and Head of Legal Services to ensure that information sharing is robust and leads to demonstrable learning from audit results, incidents and complaints. Where the Risk Register records clinical audits required as part of action plans, these will be included on the audit programme and their execution monitored.

18. MONITORING COMPLIANCE

18.1 Progress against the clinical audit programme will be monitored by the Clinical Audit and Effectiveness. This will be achieved by quarterly examination of the audit programme to determine the number and nature of audits registered against the clinical audit programme and completion of audits, with emphasis on critical and high priority projects. Any concerns will be raised in writing to the appropriate Clinical Audit Lead and the Associate Director and the Divisional Medical Director. Projects deemed to be necessary for completion that have yet to be commenced will be carried forward to the following year.

18.2 Quarterly and annual reports will be prepared by the Clinical Audit and Effectiveness Department using the database and sent to Clinical Audit Leads, Associate Directors and Divisional Medical Directors , and discussed in the at Divisional performance review meetings, and will provide evidence for effectiveness of this audit policy in terms of:

- Registration and completion of projects, with priority as a consideration
- Evidence of presentation of findings

- Recording of results and actions confirming good practice, remedial action or identification and registration of risk
- Participation in approved national projects

The database will provide information on specific audits showing:

- Improvements in patient care
- Remedial actions taken in response to identification of shortcomings
- Evidence of good practice

A proportion of these audits will be described in the annual report.

18.3 The Clinical Audit database will enable monitoring of the policy. Quarterly reports will identify non-compliance with the policy including:

- Failure to complete and deliver audits
- Lack of action planning
- Failure to record audit results and actions taken

Divisions will be apprised of progress against the clinical audit programme. Any shortcomings in, or barriers to, execution of action plans will be escalated to divisional governance leads for action or escalation as appropriate.

18.4 Clinical Audit Leads and audit supervisors will be provided with evidence of effectiveness for the purpose of appraisal measured by:

- Completion of approved projects, and resulting actions

18.5 Effectiveness of training will be monitored by the quality of audits presented at junior doctors' showcases, together with records of formal assessments.

19. REFERENCES

1. The NHS Plan, Department of Health 2000; paragraph 10.10
2. Care Quality Commission
3. New Principles of Best Practice in Clinical Audit; HQIP 2011
4. Role Description for Clinical Audit Leads, Burton Hospitals NHS Foundation Trust, June 2013
5. Clinical Audit and Effectiveness Committee Terms of Reference, Burton Hospitals NHS Foundation Trust
6. Best Practice Policy (Policy 88), Burton Hospitals NHS Foundation Trust
7. Participation in National Clinical Audits, Burton Hospitals NHS Foundation Trust Version 7 July 2014
8. Clinical Audit: A simple guide for NHS boards & partners; HQIP 2009
9. Health Record Keeping Policy (Policy 86), Burton Hospitals NHS Foundation Trust
10. Patient and Public Engagement in Clinical Audit; HQIP 2009

20. OTHER RELATED DOCUMENTS

1. Confidentiality Policy (Policy 41), Burton Hospitals NHS Foundation Trust
2. Information Governance Policy (Policy 5), Burton Hospitals NHS Foundation Trust

3. Incident and serious incident management policy and process (Policy 256), Burton Hospitals NHS Foundation Trust
4. Managing Intellectual Property Policy (Policy 117), Burton Hospitals NHS Foundation Trust
5. Research Governance Framework, Department of Health 2001

Appendix A

ID No: Audit Use Only

BURTON HOSPITALS NHS FOUNDATION TRUST

Clinical Audit Proposal Form

Please return/post the completed proposal form and other documents to the: Clinical Effectiveness and Audit Team, The House.

One form must be completed for each project you wish to undertake. All sections of the form must be completed. See help notes attached. If you need further advice please call Clinical Audit on extension 5418 or 5723

A **Project Title:**

B

Audit Specialty	

C

Project Team			
Name	Job Title	Specialty/Department	Contact/Bleep

D

Audit Standard			
Organisation (e.g. NICE)		**Year of Issue**	

E **Reason(s) for Project**

National Audit	☐	CQC	☐	Local/Regional Guidelines	☐
NHSLA	☐	Litigation	☐	Complaints	☐
NICE Guidelines	☐	Benchmark	☐	Risk Register (locally identified risk)	☐
Clinical Incident	☐	Re-Audit	☐	External Report (e.g. NCE)	☐
Professional Body	☐	Identified Quality Concerns	☐	Cost/Service Assessment	☐
Pilot	☐			Other _____	

F **Priority of Audit**

Critical – national audits only ☐ **High** ☐ **Routine** ☐

G **Other Specialties**

Please indicate below any other specialty or specialties whose work might affect the results of the project, or who might benefit from participation in the project or by receiving the project report:

_____

H **Aims and Objectives**

I

Audit Support – You should carry out as much of your own project as you are able

Do you require any help from the Audit Team? Yes ☐ No ☐

If Yes? Identify Patients* ☐ Pro forma design ☐ Order notes ☐
Input data ☐ Analyse data ☐ Presentation ☐
Word report ☐ Training ☐

Other help:

NB * If you wish for help to ID Patients , please complete the **Additional Information Sheet**
(this can be found on the Intranet Site)

J

Data Collection

Data collection proforma ☐ Prospective ☐
Questionnaire ☐ Retrospective ☐ Other : _____

Please attach a copy of your audit tool where possible or send a copy once it is complete.
NB: If you are not presenting your audit findings at a specialty audit meeting, please state how you intend to disseminate the information

K

Completion date **Proposed presentation date**

L

Data Source

Patient record ☐
HISS ☐
Patient outcomes ☐
Observation ☐
Staff experience ☐
Other: _____

Patient records required Yes** ☐ No ☐

If Yes please complete the **Additional Information Sheet
(this can be found on CEA Intranet Site)

M

Information Governance and Data Protection

Where will the data be held? _____
For how long will the data be held? _____
Who will be responsible for its security and disposal? _____

N

Sign Off

Audit / Project Supervisor	Audit Lead for Specialty/Department
Name:	Name:
Post:	Post:
Specialty/Department:	Specialty/Department:
Signature:	**Signature:**

By signing this registration form as **Audit / Project Supervisor** you are agreeing to ensure that the audit is carried out fully, ensure that a copy of the report or presentation is sent to the Clinical Audit Team after the audit meeting and complete and return follow up trail forms to CAE Team after an interval of 3 months or other interval agreed in action planning.

By signing this registration form as **Audit Lead** you are agreeing to support the principles of the project, ensure that the results are appropriately disseminated and discussed, lead on the development and implementation of an action plan (if required), and ensure that re-audit is planned for the future as necessary.

A**ppendix B**

BURTON HOSPITALS NHS FOUNDATION TRUST

Template for Clinical Audit Report

This document should be used both as the guidance notes and as the report template. The report may be produced either as a Word document or as a slide presentation, but the format should follow the same sequence in either case.

Title Page / Slide

Trust Name

Hospital Name(s)

Clinical Division(s)

Department(s)

Title of the project followed by the registration number (in brackets).

Where applicable, the following should be included in the project title:

- Whether the project is a re-audit
- Whether the project has been undertaken on a national, regional or local basis

Project team

- Name and job title of supervisor or lead
- Name and job titles of other staff participating

Date of presentation or discussion

Background / Rationale

Brief description of the reason for undertaking the project. Might be:

- Re-audit to check efficacy of changes
- Introduction of new guideline, e.g. NICE
- Research-based evidence of best practice
- Incident(s)
- Complaint(s)
- Audit as part of action plan

Aim

The aim of the audit should be specific, e.g. “To assess compliance with College of Emergency Medicine standard for fractured neck of femur” rather than “To improve patient care”.

Objectives

The objectives describe the steps you have taken to answer the audit question, e.g. “Was pain assessed and managed appropriately?”

Standards / guidelines / evidence base

State the standard title, source and year of publication, e.g. Obstetric Cholestasis, Green-top Guideline 43, Royal College of Obstetricians & Gynaecologists, 2011.

Method

Method should include:

Sample and how it was derived, e.g. “All inpatient children aged 16 or under with a primary diagnosis of asthma admitted during 2010 were included”. You should give the total number of patients in the population as well as the number in your sample, and any reason for choosing the sample, e.g. “During the audit period, 150 patients were admitted. The audit is based on a random selection of 50 patients identified by including every 3rd patient consecutively by admission date”, or “45 patients were excluded as their notes were unavailable for review”.

Describe how you identified your patients, i.e. through ICD 10 codes, from a ward or theatre register, prospectively etc.

Data source, e.g. paper record, HISS, consent forms, observation etc.

Data collected should be described, and you can append a copy of the audit tool for illustration and future reference for re-audit. You should record whether data was collected retrospectively or prospectively.

Data validation methods should be described, e.g. 10% double review by a second auditor.

Data analysis should be described, including use of analysis software such as Excel or Minitab.

Results

Be sure to quote “N”, the number of cases included in the audit. Compliance with standards may be described either by number or percent, depending on (a) how many cases have been included (lower numbers are less meaningful as percentages) and (b) whether you are comparing two groups of cases of different sizes. For example, if you are comparing the results of an audit undertaken in 2008 of 57 cases with those of an audit undertaken in 2012 of 71 cases, you should quote results in percentages to allow for meaningful interpretation.

You should also be sure to explain any discrepancies, e.g. “one patient was excluded from the analysis of 3 criteria owing to premature interruption of treatment”.

Make sure that any graphic representation of results is clear, accurate and meaningful.

Limitations and learning points

Make clear any limitations of the audit, such as low numbers of patients who could be included or problems associated with documentation. This is also where you can record anything you learned during execution of the audit that might help improve future re-audit.

Discussion

Your discussion should be a synthesis of the data, in which you consider the implications of the results, e.g. “Generally staff were well aware of the process for prescribing oxygen, but we found that management of oxygen cylinders varied across wards”.

Recommendations

Recommendations should be clear and achievable. They should relate directly to the findings of the audit and should be precise, e.g. “Teaching for junior doctors to explain why the pain assessment should be documented should form part of the next monthly meeting and re-audit should take place in six months to assess its effectiveness”, rather than “Improve staff awareness”.

Conclusions

Summarise the results, and be sure to give praise where it is due. The purposes of clinical audit are not only to uncover problems, but also to demonstrate quality. “Overall the audit showed good compliance with the standards for observations during blood transfusion, but several points were identified that would warrant attention”.

References

Provide references where appropriate, and be sure to acknowledge the work of others.