Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Clinical Audit Strategy and Policy

This procedural document supersedes: CORP/RISK 19 v.1 - Clinical Audit Policy

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Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
Version 2	18 October 2016	Revision and change from Policy to a Strategy and Policy document – Please read in full	R Dickinson

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1. INTRODUCTION

Looking forward to our future - Our Strategic Direction: 2013-17 sets out the vision, mission and values of the Trust. The vision is to be recognised as the best healthcare provider in our class, consistently performing within the top 10% nationally. The mission is to safeguard the health and well-being of the population we serve, to add life to years and years to life. This is supported by the demonstration of the way and effectiveness our patients are cared for.

The values we aim to show We Care For You are:

- **W**e always put the patient first.
- **E**veryone counts – we treat each other with courtesy, honesty, respect and dignity.
- **C**ommitted to quality and continuously improving patient experience.
- **A**lways caring and compassionate.
- **R**esponsible and accountable for our actions – taking pride in our work.
- **E**ncouraging and valuing our diverse staff and rewarding ability and innovation.

Clinical audit is one tool in the wider quality improvement strategy aimed at providing assurance of delivery best practice. This strategy sets out the principles of when clinical audit should be used and will clarify how the development of the clinical audit plan can be achieved, placing patients first. The application of the strategic direction to clinical audit is described in this strategy, contributing to the range of quality improvement activities and governance arrangements of the Trust.

2. PURPOSE

This strategy sets out the Trusts commitment to quality and effectiveness through the application of clinical audit to support delivery of:

- High quality, safe care for patients using our services.
- Cost-effective clinical services to ensure that care is both sustainable and effective
- National Audit engagement at a local level.
- The Trust Quality Account as part of the Trust Annual Report.
- Compliance to regulatory requirements from NHS Improvement and the Care Quality Commission.
- Reports on the compliance with clinical standards that can be used for assurance.
- Quality improvement as part of the national and local Commissioning for Quality and Innovation (CQUIN) targets and local Clinical Commissioning Group initiatives.
- Quality improvement projects and local audits that are aligned to the Trusts priorities for improving care.
- Demonstrable NICE compliance and best practice evidence implementation.

The methods for identifying the quality priorities and their local application are described, to provide a structured and systematic approach to measurement, improvement and assurance as part of the clinical governance functions of the Trust. This scope applies to all clinical services

and staff and provides a framework for supporting the strategies in place for continuous quality improvement.

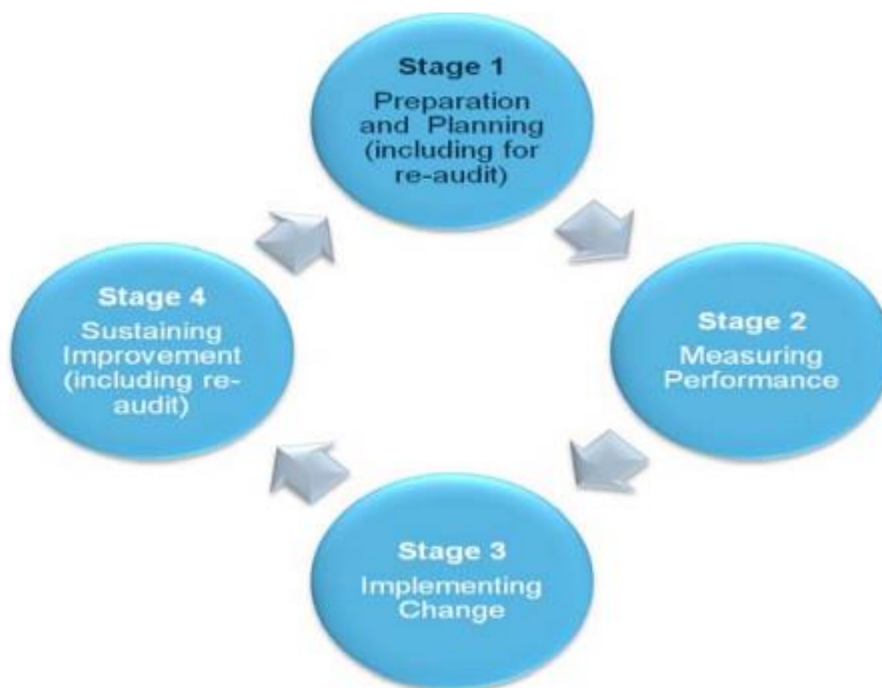
3. WHAT IS CLINICAL AUDIT?

The National Institute for Health and Clinical Excellence (NICE) describe 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. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery" (NICE 2002)*

Clinical Audit Cycle

The diagram below represents how the Trust provides a structured approach to the clinical audit process and the cycle that this takes.



It is a continuous cycle of:

- Deciding which topics to audit - based on the Trust Priorities, assurance requirements and as part of improvement plans.
- Measuring care delivered against standards – collecting data, analysing and measuring performance.
- Acting on the findings – making improvements and changes, evidenced through action plans, presentations and implementing change.
- Sustaining improvements, including re-audit where necessary, based on the priorities of the Trust and assurance needs.

4. ROLES AND RESPONSIBILITIES

The **Chief Executive** is responsible for ensuring that systems are in place to facilitate the delivery of safe and effective patient care and for the effective prioritisation of participation in national and local clinical audit.

The **Medical Director** is the Executive Lead for Clinical Audit and is responsible for providing assurance to the Board of Directors that services are safe and effective for the effective prioritisation of national and local clinical audit.

The **Quality and Effectiveness Committee** provides the formal process for reviewing the application of NICE best practice guidance, managing the cycle of clinical audits and monitoring action plan completion. The membership includes representatives from each Care Group. This committee reports to the Clinical Governance and Quality Committee, which in turn, reports to the Clinical Governance Oversight Committee, as a subcommittee of the Board of Directors. The committee will provide:

- The prioritisation for national and local clinical audit based on patient safety and effective care, mindful of the resource allocation and inclusive of re-audit sufficient to demonstrate sustained implementation.
- The forward plan for clinical audit activity and review reports on progress.
- Plan the annual Clinical Audit day recognising the improvement and useful application of local audit.
- Provide the resolution of any resource allocation for any demands arising outside of the clinical audit forward plan.

Clinical Governance

The Trust’s clinical governance structure and processes are designed to provide the Trust Board with the assurance that the quality of service level care to patients is of a high standard and that where there a need for improvement has been identified, that action is taken to improve. Recognising the Trust’s priorities for safeguarding the health of the population that we serve, we must link the monitoring and surveillance functions, the local and national priorities and the expertise of the clinicians actively working within the Trust so that they can work with the Trust to improve the quality of care provided.

Clinical Audit and Governance Leads are responsible for:

- Prioritising the local audit allocation for their services, with approval duties for the local audit applications, considering the clinical governance issues identified and inclusive of clinical pathways with risks from the mortality and morbidity and frequency to optimise the quality of care provided.
- Ensuring contribution to the national audit programs relevant to their specialties.
- Escalating significant risks through the clinical governance arrangements.
- Monitoring and promoting the engagement in clinical audit activities.
- Assessing the gap in NICE guidance publications and identification of audit need.
- Ensure that the quality of supervision of audits undertaken by training doctors is appropriate.

- Enabling the continuation of audits during and following rotation of training doctors.
- Optimising the opportunity for multi-disciplinary audits, in planning, data collection and analysis.

Quality and Effectiveness Department

The Head of Quality and Effectiveness will lead the provision of support and training for local systems on clinical audit and quality improvement principles. The monitoring of NICE guidance implementation and gap analysis process will also support the identification of local audit needs. The clinical audit facilitation will include:

- Assuring the quality of the audit proposal, design, application and project completion.
- Provide advice to clinicians and managers on audit.
- Support and advise on the collation of the clinical audit data, assisting with analysis where required.
- Provide training as required.
- Supporting the clinical audit forward plan activities as agreed by the Quality and Effectiveness Committee

Board of Directors sub-committees (assurance committees of the Board of Directors)

The Clinical Governance Oversight Committee and the Audit and Non-clinical Risk Committee are sub committees of the Trust Board of Directors. The Clinical Governance Oversight Committee are provided with twice yearly reports on the audit cycle, based on the Forward Plan annual planning cycle, with the context of aligning clinical priorities. The Audit and Non-clinical Risk Committee is also provided with twice yearly reports on the Forward Plan and audit completion in line with the monitoring activities for the Internal Audit function.

5. CLINICAL AUDIT FORWARD PLAN

A fundamental process for planning and delivering the activity of clinical audit and contributing to quality improvement is the clinical audit forward plan. This is designed to take into account the national audit programme from externally driven priorities, coupled with the clinical risks identified through the clinical governance processes. This will include the learning from the reactive processes of complaints, claims, incidents, inquest outcomes and the analysis of these activities. It will also include proactive processes such as patient surveys, best practice guidance, confidential enquiries, national audit reports, CQC reports, NHS Improvement reports, external benchmarking activities and initiatives with commissioners.

Opportunities to consult with patient representatives should be sought in the design of the Forward Plan and so consulting with the Patient Experience and Engagement Committee is expected in the development of the plan.

The forward audit plan will describe the rationale of the audit proposed, and so demonstrate how it will align to the priorities for the Trust. The content of the audit plan is agreed through the Quality and Effectiveness Committee, with local specialty Clinical Audit Leads and care group Clinical Governance Leads contributing their audits based on the outcomes from their specialty

and Care Group governance activities. The outcome of the audit should also be reported and this destination example is shown in the table below, along with the source or indication for an audit.

Source/Audit indication
National Audit Program
Complaints
Patient Survey
Incident reporting
Serious Incidents
Claims
Inquest/HM Coroner findings
Clinical Governance triangulation
External Benchmark
Commissioner concern
Mortality review process
CQUIN
Contract requirement
Best Practice

Reporting destination
National Audit Lead/System
Care Group Audit Meeting
Care Group Clinical Governance
Quality and Effectiveness Committee
Specialty Clinical Governance
Friday Lunchtime Lecture
Trainee Doctor Education
Trust Board of Directors
Mortality Monitoring Group
Commissioner
Regional Network

The Forward Plan will include links to the Trusts strategic objectives on the Board Assurance Framework to assist in the read across and assurance plans for clinically focused objectives and corporate risks.

Resources

The following categories provide a prioritisation framework where the source or indication for the audit comes from:

Category A

- National Audits, National Confidential Enquiries (NCEPOD) and Care Quality Commission Reports
- National Clinical Audit and Patient Outcome Programme (NCAPOP) mandated audits
- Contracted Quality Measures
- CQUIN framework

Category B

- NICE or NSF Guidance
- Projects identified through Clinical Risk Management mechanisms. For example, incident reporting, NHS-LA, complaints and litigation
- High risk identified from the Risk Register (Risk Score 10+)
- Poor clinical outcome/performance
- Projects identified via Patient Advice and Liaison Service (PALS)
- Projects identified by the local Commissioners

Category C

- Individual interests
- Professional guidance (Royal Colleges, Specialist Societies, International Guidelines)

- High volume/high cost procedures
- Trust/Specialty priorities

6. TRAINING/ SUPPORT

The Quality and Effectiveness Department provides training and support to equip all staff with the ability to participate fully in the continuous audit process of the Trust's services. This is achieved mainly through running workshops, on all three sites, open to all staff.

7. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Audit completion, progress and reporting outcomes	Head of Quality and Effectiveness	Twice a year	Review of Forward Plan/ Quality and Effectiveness Committee. Actions logged when required.
Audit action plan	Head of Quality and Effectiveness	Monthly	Review of action plans/ Quality and Effectiveness Committee. Actions logged when required.
Forward Plan production	Chair of Q&EC	Annually	Clinical Governance and Quality Committee
Forward Plan mid-year progress report	Chair of Q&EC	Annually (Quarter 3/4)	Clinical Governance and Quality Committee

8. DEFINITIONS

Standard – The expected level of compliance to a criterion
Criterion – The specific requirement of a clinical activity process

9. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. See Appendix 2.

9. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Mental Capacity Act 2005 Policy and Procedure - PAT/PA 19
Privacy and Dignity Policy - PAT/PA 28

10. REFERENCES & BIBLIOGRAPHY

NHS England Clinical Audit guidance, NHS England (2016)
https://www.england.nhs.uk/ourwork/qual-clin-lead/clinaudit/

Healthcare Quality Improvement Partnership http://www.hqip.org.uk/

The National Clinical Audit Programme http://www.hqip.org.uk/national-programmes/a-z-of-nca/

National Institute for Health and Care Excellence https://www.nice.org.uk/

Clinical audit: a guide for NHS board and partners; Health Foundation & Good Governance Institute (2015) http://www.good-governance.org.uk/wp-content/uploads/2015/01/CA-Guide-.pdf

A clear road ahead; Health Foundation (2016)
http://www.health.org.uk/sites/health/files/AClearRoadAhead.pdf

APPENDIX 1 – APPROVED AUDIT PROCESS

Planning

- Identify an audit that is aligned to the Trust priorities in the specialty where you work and then discuss your potential audit with your supervisor/sponsor and the Quality and Effectiveness Department.
- Identify standards/objectives (NICE, Royal College, CQUIN, Service Review etc).
- Complete Project Support Form and seek approval by the Care Group Governance Lead. Provide to the Quality and Effectiveness Department so that the audit can be registered.
- Auditor should supply criterion and standards with a suggested data collection tool.
- Design data collection tool/patient survey with assistance from Quality and Effectiveness Department where necessary and ensure this corresponds with standards.
- All patient surveys must be approved by the Quality and Effectiveness Department prior to dissemination, following readers panel feedback to enable patient involvement and interpretation, as an patient engagement activity.

Data collection

- For audits which require patient case notes then a list of patients should be supplied to the Quality and Effectiveness Department. If a list is not available then the Quality and Effectiveness Department can request a list from the Information Department although this may take up to two weeks to be available.
- Patient casenotes are requested from Health Records at the rate of 20 sets per week per audit. If notes are not available from Health Records then your available notes for that week will be reduced.
- Pilot data collection tool and make any necessary amendments.
- Commence data collection.

Analysis

- Data can be returned to the Quality and Effectiveness Department for analysis or you may wish to do this yourself.

Report and recommendations

- Reports and presentations can be produced by the Quality and Effectiveness Department or you may wish to do this yourself. Report and presentation templates are available on the Intranet.
- Results to be presented at Audit and Governance meeting and an Action Plan formulated where necessary.
- Action plans should be agreed with the sponsor and audit lead, to ensure that they are specific, measurable, achievable, assigned to an appropriate responsible person and timely.
- Final report/ presentation should be returned to the Quality and Effectiveness Department.

Monitoring Action Plan

- Action plan monitoring should be undertaken in the Specialty and Care Group concerned, reported to the Quality and Effectiveness Team.

APPENDIX 2 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	**Care Group/Executive Directorate and Department**	**Assessor (s)**	**New or Existing Service or Policy?**	**Date of Assessment**
CORP/RISK 19 v.2 – Clinical Audit Strategy and Policy	Directorate of Nursing Services	R Dickinson	Existing	16/8/16

1) **Who is responsible for this policy?** Name of Care Group/Directorate *Directorate of Nursing Services*

2) **Describe the purpose of the service / function / policy / project/ strategy?** Who is it intended to benefit? What are the intended outcomes? *To provide a structured approach for all clinical staff who are involved in clinical audit and quality measurement.*

3) **Are there any associated objectives?** Legislation, targets national expectation, standards *National Audit agenda, Clinical Governance HSC*

4) **What factors contribute or detract from achieving intended outcomes?** –

5) **Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief?** Details: [see Equality Impact Assessment Guidance] - *No*

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) **Is there any scope for new measures which would promote equality?** [any actions to be taken] - *No*

7) **Are any of the following groups adversely affected by the policy?**

Protected Characteristics	**Affected?**	**Impact**
a) Age	No	*No*
b) Disability	No	*No*
c) Gender	No	*No*
d) Gender Reassignment	No	*No*
e) Marriage/Civil Partnership	No	*No*
f) Maternity/Pregnancy	No	*No*
g) Race	No	*No*
h) Religion/Belief	No	*No*
i) Sexual Orientation	No	*No*

8) **Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box**

Outcome 1 ✓	**Outcome 2**	**Outcome 3**	**Outcome 4**

Date for next review: July 2019

Checked by: R Dickinson **Date: 16.8.2016**