Livewell Southwest

Audit Policy (Clinical)

Version No 3.4

Review: May 2019

Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent and procedural version of this guidance. Staff must ensure they are using the most recent guidance.

Author: **Quality Improvement Support Team (QUIST) & Professional Lead**

Asset Number: **87**

Reader Information

Title	Audit Policy (Clinical) V.3.4
Asset number	87
Rights of access	Public
Type of paper	Policy
Category	Clinical
Document purpose/summary	Guidance to staff undertaking clinical audit.
Author	Quality Improvement Support Team and Professional Lead
Ratification date and group	9th May 2016
Publication date	12th May 2016
Review date and frequency (one, two or three years based on risk assessment)	Three years after publication, or earlier if there is a change in evidence.
Disposal date	The Policy Ratification Group will retain an e-signed copy for the archive in accordance with the Retention and Disposal Schedule; all copies must be destroyed when replaced by a new version or withdrawn from circulation.
Job title	QUIST Team and Professional Lead
Target audience	Staff working within Livewell South West
Circulation	Electronic: Livewell Southwest (LSW) intranet and website (if applicable) Written: Upon request to the PRG Secretary on ☏ 01752 435104. Please contact the author if you require this document in an alternative format.
Consultation process	Quality Improvement Service Team Locality Managers and teams, Medical staff Pharmacy staff
Equality analysis checklist completed	Yes
References/sources of information	Collins Concise Dictionary. Harper Collins. (1998) Clinical Audit and the Audit Commission. Health Quality Improvement Partnership (November 2009) NICE Assurance Policy for Commissioning Services. Livewell South West. Version 1.2. (2010) NHS Executive 1997 See Review of Ethics and Clinical Audit and Quality Improvement Literature, Guide on Ethics and Clinical Audit and Template for Policy on Ethics and Clinical Audit available from HQIP. **Key policy driver references** 'Working for Patients' (Government White Paper, 1989)

	The New NHS — Modern Dependable (Department of Health, 1997) A First Class Service (Department of Health, 1998) Clinical Governance — Quality in the NHS (Department of Health, 1999) Learning from Bristol: the report of the public inquiry into children's heart surgery at Bristol Royal Infirmary 1984–1995 [the 'Kennedy Report'] (Department of Health, 2002) Good Medical Practice (General Medical Council, 2006) National Standards, Local Action Good Doctors Safer Patients (Department of Health, 2006) Trust Assurance & Safety (Department of Health, 2007) The NHS Next Stage Review Final Report, High Quality Care For All [the 'Darzi Report'], (Department of Health, 2008). NHSLA Risk Management Standards included standard 5-Criterion 1: Clinical Audit. 2010 Equity and excellence: Liberating the NHS (Department of Health,2010) The Good Medical Practice Framework for appraisal and revalidation (GMC 2012) Records Management: NHS Code of Practice 2006
Associated documentation	• Clinical Record and Note Keeping policy • NICE assurance policy • Honorary Contracts, Visitors Declarations and Contracts for Services Policy
Supersedes document	Audit Policy (Clinical) V3.3
Author contact details	By post: Local Care Centre Mount Gould Hospital, 200 Mount Gould Road, Plymouth, Devon. PL4 7PY. Tel: 0845 155 8085, Fax: 01752 272522 (LCC Reception).

Document review history

Version no.	Type of change	Date	Originator of change	Description of change
0.1				New Policy
0.2		December 2008	Clinical Effectiveness Team	Edit re NICE Clinical Audit
1.0		January 2009	Clinical Effectiveness Team	Minor presentation amendments & ratification.
1.1	Update policy	October 2010	QUIST and DDPP	Amended
2	Ratified	November 2010	Policy Ratification group.	Appendix B added.
2.1	Extended	January 2013	Professional Lead	Extended, no changes.
2.2	Extended	July 2013	Professional Lead	Extended, no changes.
2.3	Extended	March 2014	Professional Lead	Extended, no changes.
2.4	Reviewed	March 2014	Professional Lead and QUIST	Minor amendments and re consultation
3	Reviewed	May 2014	Professional Lead and QUIST	Major review. Comments from Consultation Process included
3.1	Amendment	December 2014	Professional Lead	Appendix B and C added.
3.2	Amendment	Jan 2016	Professional Lead	Minor amendments to reporting processes
3.3	amendment	April 2016	Professional Lead	Final draft for consultation
3.4	Final sent for ratification	May 2016	Professional Lead	No further comments on reviewed policy / paperwork

Audit Policy (Clinical)

1 Introduction

1.1 There has been a succession of key national publications spanning two decades, each of which underlines the expectation that all healthcare professionals participate in clinical audit on a regular basis. Furthermore, since 2008 there has been a shift in the national clinical audit strategy, which has seen the 'reinvigoration' of clinical audit at a local level.

1.2 Whilst over the years the definition of clinical audit has undergone some modification, it has always emphasised that clinical audit is an integral part of quality improvement. Principles for Best Practice in Clinical Audit (2002), produced in collaboration with the Healthcare Commission (HCC) and the National Institute for Health and Care Excellence (NICE), defines clinical audit as: -

1.3 'Clinical audit is a quality improvement process that seeks to improve the patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structures, 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'.

1.4 The second edition," New Principles of Best Practice in Clinical Audit" (2011) edited by Robin Burgess of the Healthcare Quality Improvement Partnership (HQIP), re-affirms:

"Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes."

1.5 By following the cycle, any clinician or team should be able to see where their practice can be improved against given benchmarks, to take action, and then to re-measure and make further improvements. Whether conducted by an individual on their own clinical work, for a whole clinical team or unit, or nationally by comparing provider in different organisations against each other, it is the same process. Its purpose is to drive up standards of quality and to achieve better outcomes."

1.6 When carried out in accordance with best practice standards, clinical audit:

- Provides assurance of compliance with clinical standards;
- Identifies and minimises risk, waste and inefficiencies;
- Improves the quality of care and patient outcomes.

1.7 Clinical audit supports Livewell South West (LSW) in meeting:

- CQC requirements – Effective, Safe, Caring, Well-Led and Responsive
- The NHS Standard Contract 2014/2015 Service Conditions Sections SC26 and GC15.
- The Department of Health Quality Accounts.
- Information requirements for appraisal and revalidation.
- CQUINs agreed with Commissioners.
- Supports future service planning requirements.

1.8 LSW supports the view that Clinical Audit is fundamentally a quality improvement process; it also plays an important role in providing assurances about the quality of services.

2 Purpose

2.1 The purpose of this policy is to set out a framework for all staff participating in clinical audit activities. This includes the rationale for undertaking clinical audit and establishes the procedures to be followed.

3 Duties and Responsibilities

- The Chief Executive is responsible to ensure the organisation undertakes national and local clinical audits.

- The Director of Professional Practice, Quality and Safety is the strategic lead for clinical audit and has overall organisational responsibility for all audits.

- A Professional Lead is the Operational Lead for clinical audit.

- Locality Managers and Deputy Locality Managers are responsible for the monitoring and resourcing of audits in their teams, as well as overseeing the implementation of action plans.

- Managers / Matrons are responsible for ensuring that service development and delivery are accurately measured. Managers also devise and implement the action plans and to support improvements and changes in practice, ensuring audit results are embedded into the culture of the service.

- The Audit Lead is responsible for registering and conducting the audit. They are also responsible for the dissemination and the completion or delegation of the action plan.

- All health staff are responsible for monitoring their practice and their learning through the use of clinical audit. Clinical Audit could also be used to evidence in annual appraisals or revalidation.

- The National Institute for Health and Care Excellence (NICE) Assurance Lead facilitates and coordinates NICE audits.

- The Quality Improvement Support Team (QUIST) undertake the facilitation / coordination and reporting needs of national and Organisational clinical audit priorities. For individual clinical teams wishing to commence an audit, the QUIST team will register and review audit methodology. They also develop and modify audit tools, analyse systems, maintain a database and produce reports where necessary for organisational and National audits. QUIST create quarterly reports against the annual audit plan. There is a clear training component within this team.

4 Definitions

NICE	National Institute for Health and Care Excellence
QUIST	Quality Improvement Support Team
HQIP	Healthcare Quality Improvement Partnership
CQC	Care Quality Commission
SQP	Safety Quality and Performance Committee
SIRI	Serious Incidents Requiring Investigation
IPAM	Integrated Provider Assurance Meeting
LSW	Livewell Southwest

5 The Audit Process in Livewell Southwest

5.1 Involving patients and the public

5.1.1 Patients and carers often assess quality in different ways to healthcare professionals: they can provide a unique perspective based on their personal experience and can help redesign services around patient's needs.

5.1.2 Livewell South West is committed to working collaboratively with service users and carers which helps to ensure that it commissions and provides relevant, appropriate and value for money services to the population of Plymouth. In addition, Livewell South West has a legal duty to involve patients and the public and to report on those activities and their outcomes.

5.1.3 Examples of patient involvement in Livewell South West audits include auditing issues highlighted by patient complaints and the patient experience manager being involved with annual audit planning.

5.2 Agreeing an annual programme of reportable activity – National and Organisational Priority Audits

Prior to the start of the financial year an annual audit plan for the organisation will be agreed. The annual plan will:

- Provide a timetable for services and managers.
- Provide evidence of quality of services.

- Promote action planning to improve quality of care.
- Ensure there is equality across localities.
- Ensure the audit plan reflects key organisational priorities including clinical issues, governance issues, commissioning and national audits
- Ensure there is evidence behind the audit in respect of what organisational priorities / drivers are behind it - a Red, Amber, Green (RAG) rating
- Be agreed and supported by the Locality Managers, Staff in Operational / Clinical Leadership roles and the Executive Team via the SQP

5.2.1 Planning the annual programme will be achieved via the following steps:

I. Meeting with main stakeholders to identify organisational priorities for the new programme, based on a review of the previous programme together with consideration of new areas of practice where an audit methodology would be appropriate and timely for either providing assurance of best practice or to support improvement to achieve best practice – this meeting will be scheduled around December and should involve:
   - Matrons
   - Professional leads
   - Medical representatives
   - Training leads
   - Clinical leads, e.g. AHP leads, children's, LD
   - Risk lead
   - Patient experience manager
   - Pharmacists

II. Seeking the views of our Commissioners about any audits they want to see included.

III. Identifying any mandatory national audits within the National Clinical Audit and Patient Outcomes Programme (NCAPOP), plus other national audits which are included in the Quality Account.

IV. Consultation with LSW senior managers/clinical leadership to seek support for the draft proposals arising from completion of Steps I to III, and to allow identification of other priorities as needed. Consultation will be with:
   - Head of Pharmacy
   - Principal Social Worker
   - Locality Managers
   - Medical Director
   - Clinical Directors
   - Director and deputy Director of Professional Practice
   - Director and deputy directors of Operations

V. Apply a RAG rating for audits on the draft organisational audit plan, using a Quality Impact Analysis tool.

VI. Seek sign-off for the Annual Organisational Priority Audit Plan from the Executive team, via SQP.

5.2.2 Livewell South West priorities for inclusion in the audit plan will include:

- National audits contained within the National Clinical Audit and Patient Outcomes Programme (managed by HQIP) and Quality Account.
- Themes from LSW Aims and SIRIs and complaints.
- NICE guidance and Quality Standards

- Acknowledging that the audit cycle includes re-audit, a proportion of topics for re-audit will also be included in the annual audit plan.

Audits are planned and prioritised on numerous factors including risk, quality, benefits etc. For each audit these factors will be available.

5.2.3 All audits included on the plan will be registered this registration form will be reviewed on receipt and the audit methodology checked. It will be placed on the Organisational Database and a confirmation will be sent to the audit lead, team manager, Locality Manager, as well as supervising consultant or senior governance lead where appropriate.

5.2.4 It is expected that additional requests for clinical audit topics will arise during the year, and the audit plan will need to be adapted accordingly. This may mean that another audit has to be rescheduled for later in the year or is removed from the audit plan. This decision will be made by the Professional Lead and QUIST team; teams will be informed of any changes to the audit plan.

5.2.5 A quarterly Update will be provided through the SQP route to IPAM. This report will cover all national and organisational priority audits. It will not include individual team audits. These will be reported annually as described below.

5.3 Individual / Clinical Team Audits

5.3.1 It is expected that requests for clinical audit topics will arise during the year, and the audit plan will need to be adapted accordingly. This may mean that another audit has to be rescheduled for later in the year or is removed from the audit plan. This decision will be made by the Professional Lead and QUIST team; teams will be informed of any changes to the audit plan.

5.3.2 It is acknowledged that teams/services may also initiate a clinical audit project on the basis of team or service interest, development or as part of an educational or training programme. It is important that these are registered with QUIST.

5.3.3 The QUIST audit registration form will be reviewed on receipt and the audit methodology checked. It will be placed on the Organisational Database and a confirmation will be sent to the audit lead, team manager, or supervising consultant and Locality Manager.

5.3.4 Team / Individual Audits – results and actions will be reported in the Annual Report for the organisation. The registration processes asks for approximate timescales for the audit and for the preparation of this report a brief update will be requested from audit leads / team managers. The locality Managers and / or supervising consultant will also be copied in.

5.4 Governance of clinical audit

5.4.1 Systems for registering and approving audits

a) The organisation has a robust process in place, which requires all clinical audit projects to be registered with the QUIST and methodology approved prior to data

collection commencing. This is irrespective of the level of facilitation being requested of the Department. Staff should complete the registration document electronically by downloading it from the intranet, saving it, and emailing the completed document to the relevant Audit Facilitator. Below is a link to the clinical audit page on Healthnet, where the documentation is held.

http://Healthnet.derriford.phnt.swest.nhs.uk/OrganisationalStructures/Departments/QualityImprovement/ClinicalAudit.aspx

b) All audit methodology, including the audit tool and appropriateness of topic selection, will be reviewed by the QUIST. If there are any outstanding concerns these will be discussed with the audit lead. All audits will be registered on the central clinical audit database. Audits can commence once an audit registration number has been issued by the QUIST.

c) When completed and registered with the QUIST team – it will be returned to the clinical audit lead, team manager, or supervising consultant as well as Locality Manager / Director (Locality Manager / for individual / team audits or Director / Locality manager for National / organisational priority audits) for their information.

d) Action plans for team / individual audits are monitored by the appropriate Locality Managers, Modern Matrons, supervising consultant or Clinical Leads and Team Managers.

5.4.2 Multi-disciplinary and multi-professional audit, and partnership working with other organisations

Multi-disciplinary and cross-organisational working are hallmarks of good clinical audit practice. Livewell South West encourages clinical audit undertaken jointly across professions and across organisational boundaries. Partnership working with other local and regional organisations will be encouraged where improvements to the patient journey may be identified through shared clinical audit activity. In addition, Livewell South West supports collaboration on multi- professional clinical audits of interest to other parts of the local health economy, both within and outside of the NHS e.g. primary/secondary care, local authorities, social services etc. There is an expectation that any cross organisational audit will require a joint action plan .It would be expected that these audits even if they are not led by Livewell South West be registered.

5.4.3 The use of standards (or criteria) in clinical audit

There is an expectation that clinical audit will involve measuring clinical practice against predetermined standards of best practice.

5.4.4 Equality and diversity

Where possible clinical audit practice will take account of equality and diversity issues. For example, clinical staff must ensure that the process for determining choice of clinical audit projects, and the manner in which project patient samples are drawn up, does not inadvertently discriminate against any groups in society based on their race, disability, gender, age, sexual orientation, religion or belief. In

addition, equality impact assessment tools are available.

5.4.5 Information governance: collection, storage and retention of data and confidentiality

a) All clinical audit activity must take account of the Data Protection Act (1998) and the Caldecott Principles (1997). This means, for example, that data should be:
   - Adequate, relevant and not excessive.
   - Accurate.
   - Processed for limited purposes.
   - Held securely for the appropriate time.

b) This policy governs the collection, storage and retention of data collected for clinical audit purposes, and follows the guidance provided in the Department of Health publication *Records Management: NHS Code of Practice* (2006) which requires "audit records" to be retained for a period of five years.

c) Clinical audit activity must also conform to the requirements of the *NHS Confidentiality Code of Practice* (2003) which states that "Patients must be made aware that the information they give may be recorded, may be shared in order to provide them with care, and may be used to support local clinical audit. Local guidance from the, Caldicott Guardian, Information Governance Lead or QUIST Team should be sought.

d) This anonymity should, wherever possible, extend to not mentioning the names of clinicians (for example where the relative 'performance' of different clinicians might otherwise be revealed in a report, the purpose of clinical audit being quality assurance and improvement, not performance management).

5.4.6 Confidentiality agreements

There may be occasions when an organisation engages individuals in its clinical audit activities that are not directly employed by that organisation, e.g. staff who are on honorary contracts, volunteers, patients and the public. It is recommended that individuals in this situation have training and sign a confidentiality agreement, please see the Honorary Contracts, Visitors Declarations and Contracts for Services Policy on the intranet for guidance.

5.5 Clinical audit database

5.5.1 There is a comprehensive clinical audit database with details of clinical audit activity, which can be accessed via the QUIST on request. This database will hold information on:

- Audit project lead.
- Audit results and action plans.
- Re audits.

5.6 Ethics and consent

By definition, clinical audit projects should not require formal approval from a Research Ethics Committee. If the QUIST are in any doubt as to the requirement for ethics committee consent, they will seek advice.

Clinical audit must always be conducted within an ethical framework, which will consider the following four principles:

a) There is a benefit to existing or future patients or others that outweighs potential burdens or risks.
b) Each patient's right to self-determination is respected.
c) Each patient's privacy and confidentiality are preserved.
d) The activity is fairly distributed across patient groups.

5.7 Provision of clinical audit training and Staff Development

Specific aspects of clinical audit require specialist skills to enable successful clinical audit, for example using the correct clinical audit methodology. This policy sets out how Livewell South West will ensure that all clinicians and other relevant staff conducting and/or managing clinical audits are given appropriate time, knowledge and skills to facilitate the successful completion of the audit cycle.

5.7.1 Training & Education:

- Training will be delivered by members of the QUIST and will be offered to all healthcare staff who are responsible for auditing the quality of care they deliver.
- The QUIST will also provide bespoke training, covering specific aspects of the clinical audit cycle; induction training for junior doctors; introductory sessions delivered in lunchtime seminars, or in the team setting etc.

5.7.2 Training and Education of clinical audit staff

Livewell South West employs a team of suitably skilled clinical audit staff to support its programme of clinical audit activity. Livewell South West will also ensure that these staff have access to further relevant training in order to maintain and develop their knowledge and skills.

5.8 Reporting and dissemination

5.8.1 Reporting and Dissemination of Audit and Clinical Effectiveness Activities - National / Organisational Priorities

Progress against the Audit Plan will be reported quarterly through the Operational SQP, SQP and IPAM.

This report will update on progress of all national audits, organisational priorities and on-going audits carried over from previous years. If indicated specific issues and lack of progress against action plans are brought to the attention of the SQP Committee via the quarterly report.

In addition, certain audits will be presented in their entirety through the Pre SQP, SQP and IPAM route when requested; this will involve the clinical audit report and action plan being shared. This will be clear when registering an audit.

In addition areas of good practice and change are highlighted in the Quarterly QUIST report.

An Annual Audit Report will summarise progress and will be available for May reporting timescales.

5.8.2 Reporting and Dissemination of Audit and Clinical Effectiveness Activities - Team / individual audit Priorities

Team / Individual clinical Audits when completed for the most part will routinely be disseminated though Locality structures. For example the Locality Manager will be aware of the audit plan, subsequent final report on completion and the action plan.

It is for the locality manager / team manager / supervising consultant to decide where the audit will be discussed - locality meeting / Pre SQP meeting or through team meetings.

All clinical audit activities are reported and can be discussed via the:

- Project lead.
- Team meetings.
- Locality Meetings
- Clinical Governance Meetings and professional forums.
- SQP and IPAM via quarterly audit report

LSW's Annual Audit Report will include a summary of individual / team audits that have been registered. To enable this reporting the QUIST team will request to receive a copy of the completed audit and action plan. This will enable the database to be updated and audits to be reported / shared if requested.

5.8.3 Project management database

All clinical audits are registered and held on a central database with details of current status for each project.

5.9 Clinical audit annual report

5.9.1 QUIST create an annual report detailing activity for LSW against the audit plan for the year.

5.10 Action plans and improvement

5.10.1 Where the results of a clinical audit indicate areas for improvement, an action plan is created. Staff should send a report of their audit including any action plan, to the Quality Improvement Support Team (QUIST). A report template is available for downloading on the LSW intranet: the link to the clinical audit page below will lead you to it, just scroll down and locate the template on the left hand side of the page.

http://Healthnet.derriford.phnt.swest.nhs.uk/OrganisationalStructures/Departments/QualityImprovement/ClinicalAudit.aspx

5.10.2 Action plans should be specific, measurable, achievable and realistic. They should have clear implementation timescales with identified leads for each action.

5.10.3 Action Plans for National and Organisational audits will be monitored by the QUIST team; there is an expectation that team / individual audits will be monitored by team manager, audit lead , supervising consultant or locality manager/ if appropriate and an update given annually.

5.10.4 Re-audit is important to determine whether agreed actions have been implemented according to the action plan. A proportion of the annual clinical audit programme should be accounted for by re-audit.

6 Monitoring effectiveness

6.1 The following systems are in place to monitor the progress of the organisation's clinical audit plan.

- Team / Individual Clinical Audits will be reported through Locality Routes / or team training, medical CPD meetings as specified in the audit registration document and escalated through the operational SQP / SQP by the locality manager – escalation could be for reasons of sharing good practice, significant concerns or ensuring consistent ways of working across teams.
- Updates are provided on request to forums such as Locality Managers meetings and individual team meetings regarding specific organisational / national audits.
- SQP Committee receives input into the quality report regarding progress of action plans, which in turn is presented to IPAM.
- An annual clinical audit report is also prepared, for presentation to the LSW Board.
- The effectiveness of individual audits is demonstrated through receipt of action plans, confirmation that action plans have been completed and the results of re-audit illustrating an improvement/change in practice.

6.2 Evidence of effectiveness of this policy will be monitored by examining whether:

- Staff are receiving training.
- There is a rigorous system for determining what goes into the annual clinical audit programme.
- Stakeholders are being involved.
- Projects are registered and approved.
- Projects are standards-based.
- Projects are meeting data protection and confidentiality guidelines.
- Results are being reported and disseminated.
- Action plans are being agreed and implemented.
- Timely progress reports are generated.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Professional Practice, Quality and Safety.

Date: 10th May 2016