journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Public – To be published on the Trust external website

Title: Clinical Audit Policy

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Contents

1 Introduction

Clinical audit is at the heart of quality improvement, assurance and effectiveness. It provides a mechanism for reviewing the quality and effectiveness of care and treatment provided to patients and ensures that best practice is consistently achieved to deliver the best possible outcomes for patients.

The expectation for healthcare professionals to participate in regular clinical audit was first published in the 1989 Government White Paper, 'Working for Patients'. This has been reinforced and extended by a succession of key national publications including The NHS Next Stage Review Final Report 'High Quality Care for All' ('The Darzi Report') Department of Health, 2008. Lord Darzi's vision is: -

> "*An NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart – quality defined as clinically effective, personal and safe".*

Clinical audit is a key component of clinical effectiveness. As such, clinical audit is a cohesive and integrated monitoring mechanism which supports delivery of effective governance, assurance and quality improvement within the organisation.

This policy is critical to the delivery of Our Journey To Change and our ambition to co-create safe and personalised care that improves the lives of people with mental health needs, learning disabilities or autism. It helps us deliver our three strategic goals as follows:

- This policy supports the Trust to co- create a great experience for all patients, carers and families from its diverse population by ensuring the delivery of outstanding and compassionate care. It details how we systematically measure the care we deliver against evidence-based best practice standards and respond to any areas for improvement. Checking that we are following best practice standards helps us deliver safer and more effective care that is personalised for each of our patients, carers and families.

- This policy supports the Trust to co-create a great experience for our colleagues ensuring that they are involved in decisions that affect them and that the workplace is fit for purpose. It does this by setting out a clear system through which colleagues can evaluate their practice, recognising success and helping guide development.

- This policy supports the Trust to be a great partner ensuring that we have a shared understanding of the needs and the strengths of our communities and work innovatively across organisational boundaries to improve services. Clinical audit also

helps us to provide quality assurance data to the organisations we work with and helps us work together to improve the support that we provide to our patients and communities.

2 Why we need this policy

The Trust supports the view that clinical audit is a quality improvement process which can be used to deliver quality assurance. Therefore, clinical audit is a strategic priority for the Trust Board as part of their quality assurance and effectiveness function. It is one of the key compliance tools at the Board's disposal and has an important role within the assurance framework.

2.1 Purpose

- To set out the Trust's arrangements for ensuring that all clinical audit activities are undertaken and completed in a systematic manner and to ensure that key processes are robustly implemented and monitored.

- To continue to develop and sustain a culture of best practice in the management and delivery of clinical audit within the Trust.

2.2 Objectives

- To define how clinical audit should operate as part of an integrated approach to quality improvement:

    - To provide the assurance mechanisms for reviewing, measuring and monitoring the quality of everyday care and treatment provided to patients.
    - To provide mechanisms to address quality and risk issues systematically and explicitly, providing reliable compliance information.

- To define how the Trust will participate in national and local clinical audits of the care, treatment and outcomes for patients in each clinical service with the overall aim of improving patient outcomes.

- To identify the clinical audit infrastructure of the Trust which facilitates delivery of good quality clinical audit

3 Scope

3.1 Who this policy applies to

This policy applies to all clinical and non-clinical staff directly employed by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) who in the course of their work are expected to contribute to clinical audit as a means of reviewing and improving patient care / treatment and their own practice.

Clinical audit is patient focused and supports the Trust's compliance with the CQC Fundamental Standards (updated August 2022).

3.2 Roles and responsibilities

Role	Responsibility
Quality and Assurance Committee	• To support the processes to ensure lessons are learned; good practice shared and implemented across the organisation. • To provide a regular opportunity to critically review areas of practice, patient experience, clinical safety and effectiveness, service development, improvement and governance.
Executive Quality Assurance and Improvement Group	• The Executive Quality Assurance and Improvement Group is responsible for encouraging and facilitating the establishment, maintenance and improvement of good clinical practice in all aspects of Adult Mental Health, Mental Health Services for Older People, Learning Disabilities, Forensics, Children & Young People's Services and Pharmacy and the provision and delivery of high quality services.
Director of Quality Governance	• Provision of operational management to the Clinical Audit and Effectiveness Team, delivering the annual operational and developmental programmes for CQC registration and clinical audit • Leadership, on behalf of the Director of Nursing and Governance, of the clinical assurance agenda supporting the deployment of clinical outcomes and patient reported outcomes systems and clinical audit together with any other areas of clinical effectiveness monitoring.

	• To be responsible for co-ordinating and monitoring all Research and Development Activity related to the portfolio of work on a regular basis. There will be a regular requirement to initiate and authorise research and audit work, including system testing for the work of the Clinical Outcomes and Patient Reported Outcomes programmes. • The research and audit work will include participation in planned R&D work as part of larger scale studies but also initiating workstreams using research and audit methodology as well as development work using the TEWV Quality Improvement System.
Service Development Manager	• To co-ordinate the ongoing research and development programme within the Service with particular emphasis on those activities relating to service development/improvement and Quality Assurance programmes. To be responsible for the effective dissemination of outcomes and sharing of learning with interested parties within and external to the Trust. • To undertake and support audit work within the Service for ensuring compliance with policies, both service-specific, trust-wide and National guidance. • To liaise with the Trust's corporate directorates and clinical service to co-ordinate a range of activities including the design and delivery of Quality Assurance programmes, service improvement events and training activities. • Co-ordinate audit activities for the Service as outlined in the Quality Assurance programme. This includes Project management of development activities and dissemination of outcomes and learning across the Service and Trust-wide or to external bodies where applicable. • To ensure that appropriate clinical audit topics are identified and clinical audits are undertaken within the service area on a regular basis as part of an annual audit plan for the area of service.
General Managers/ Service Managers/ Deputy Chief	• Audit and evaluation of service standards and practice.

Pharmacist/ Safeguarding Public Protection Team (governance)	• To develop and ensure audits are undertaken within the Service to improve performance management of the service teams.
All Clinical Staff	• All professionally affiliated clinical staff have a responsibility to participate in clinical audit activity.
Head of Quality Governance and Compliance	• Responsible for providing support to clinical and corporate staff to ensure the delivery of the Quality Assurance Programme. • To lead and performance manage the development and delivery of the annual Quality Assurance programme.
Clinical Audit and Effectiveness Lead	• Lead on the implementation of an annual Quality Assurance programme to demonstrate Trust compliance in respect of Care Quality Commission Registration and Quality Account requirements. • Responsible for the maintenance and continual improvement of the electronic clinical audit management system for collation of evidence in respect of regulatory requirements. • To horizon scan national and local clinical audit and effectiveness priorities to lead on the development and delivery of Quality Assurance programmes. • To work closely and liaise with Quality Assurance Facilitators to deliver the Trust Quality Assurance programme. • Ensure that systems and processes are in line with internal and external audit measures.
Quality Assurance Facilitator	• Provide key support, advice and instruction to staff at all levels within the Trust to facilitate the delivery of clinical audit projects. • Provide background and criteria for audit projects by identifying relevant Trust policies and National guidance using internet searches and other relevant publications. • Initiate meetings with project teams to assess and take forward clinical audit projects. • Design customised data collection tools using relevant background information and criteria.

	• Be aware of patient involvement techniques and devise patient involvement audit tools as required. • Identify and extract raw data from clinical records, computer databases and other sources and organise data for quantitative and qualitative analysis. • Work within clinical areas Trust-wide as required to undertake/ facilitate audits. • Determine most appropriate format for analysing simple and complex data and create customised databases using Microsoft Excel. • Accurately input data, dealing with anomalies and clarifying irregularities with project team. • Write queries and formulae to interrogate, manipulate and interpret quantitative data. • Based on the quantitative and qualitative analysis of data write clear, concise and comprehensive clinical audit reports, suggest areas of good practice and where appropriate propose recommendations to improve services. Reports can impact upon clinical policies, procedures and training within the Trust. • Distribute clinical audit reports to all essential and interested parties. • Contribute and participate in regular meetings with the clinical audit and effectiveness networks, performing follow up actions as necessary. • Update and maintain the Clinical Audit Database in order to record Trust-wide audit activity and facilitate reporting.

4 Policy

It is the intention of the Trust that clinical audit activities will:

- Be used to facilitate quality improvement and quality assurance

• Be conducted as a component of a structured annual Quality Assurance programme or as an approved project to facilitate local quality improvement and/ or individual professional development (Procedure 1)
• Be patient focused, concentrating on key quality and risk priorities
• Be registered with the Clinical Audit & Effectiveness Team (Procedure 2 and 3)
• Be captured on the Trust Clinical Audit Database
• Be based on evidence-based criteria as derived from local and National / International best practice guidance, policies and procedures (Procedure 4)
• Measure standards of practice for stipulated audit criteria (Procedures 5 -7)
• Lead to planned actions and changes in practice (improvements) where indicated (Procedure 9 and 11)
• Be monitored, reported and communicated as appropriate to relevant strategic and operational staff, Groups and Committees; including the Quality Assurance Committee and Care Group Quality Assurance and Improvement Groups (Procedure 10 - 12)
• Be shared with Partner organisations and the wider health communities to facilitate lessons learnt
• Process confidential patient information for the purpose of clinical audit and health related provision and outcomes (The Health Service (Control of Patient Information) Regulations, 2002)
• Clinical audit activities will be conducted in accordance with the referenced procedures.

5 Definitions

Term	Definition
Clinical Audit	The National Institute for Health And Clinical Excellence (NICE) define 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" ('Principles for Best Practice in Clinical Audit', NICE 2002)

6 Related documents

6.1 Procedures

Procedure Number	Procedure
01	Development of Annual Quality Assurance Programme
02	Project Registration (Programmed Projects)
03	Project Registration (Adhoc and Trainee Doctor)
04	Audit tool/Questionnaire development (Programmed Projects)
05	Data Collection (Programmed Projects)
06	Data Analysis
07	Draft Report
08	Compliance and Quality Assurance
09	Final Report and Action Plan
10	Dissemination
11	Monitoring and Implementation of Action Plan (Programmed Projects including IPC)
12	Tracking, Monitoring and Reporting of Clinical Audit and Effectiveness Activity

Procedure Number	Procedure
13	Programme Amendments
14	Infection Prevention and Control (IPC) Audits

7 How this policy will be implemented

The Clinical Audit Policy will be implemented via the existing clinical and corporate infrastructure within the Trust and further supported by the delivery of the Clinical Audit Procedure Manual.

This policy will be published on the intranet and the Trust website.

7.1 Implementation action plan

Not applicable – this is an existing policy embedded within Trust systems and processes.

7.2 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Quality Assurance Facilitators	In-house training through induction, following updates, and as required within supervision and in Team Development Meetings	2 hours	Annual within Team Development meetings as required

8 How the implementation of this policy will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).

1	Time taken from receipt of clinical audit data to dissemination of clinical audit reports to services	All Quality Assurance Facilitators recording dates on the programme at point of dissemination. KPIs monitored by Clinical Audit and Effectiveness Lead.	KPIs reported directorate management team. In exception any significant performance issues are raised to the Executive Quality Assurance and Improvement Group (EQAIG). Monthly Progress Update reports are produced and reported to Executive Quality Assurance and Improvement Group and Quality Assurance Committee.
2	Tracking the status of actions resulting from clinical audit activities including IPC action plans.	All Quality Assurance Facilitators review the Action Monitoring Matrix at least monthly to ensure follow up of actions is provided and outstanding actions are escalated to relevant colleagues/groups as outlined in the Procedural Manual.	KPIs reported directorate management team. In exception any significant performance issues are raised to the Executive Quality Assurance and Improvement Group (EQAIG). Monthly Progress Update reports are produced and reported to Executive Quality Assurance and Improvement Group and Quality Assurance Committee.

Internal audit of the Clinical Audit Policy and associated procedures will be conducted intermittently and reported to the Executive Director of Nursing and Governance and the Executive Quality Assurance and Improvement Group (EQAIG).

9 References

- 1989 Government White Paper, 'Working for Patients'.
- The NHS Next Stage Review Final Report 'High Quality Care for All' ('The Darzi Report') Department of Health, 2008
- CQC Fundamental Standards, Updated August 2022, https://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards
- Principles for Best Practice in Clinical Audit, NICE 2002
- The Health Service (Control of Patient Information) Regulations, 2002, http://www.legislation.gov.uk/uksi/2002/1438/contents/made
- Clinical Audit: A Simple Guide for NHS Boards and Partners (2010)
- Guide to Using Quality Improvement Tools to Drive Clinical Audit (2010)
- Good Governance Handbook (2012)
- Healthcare Quality Improvement Partnership (HQIP) Publications

10 Document control (external)

Date of approval	15 February 2023
Next review date	15 February 2026
This document replaces	CORP/0053/v3 Clinical Audit Policy
This document was approved by	Executive Quality Assurance and Improvement Group (EQAIG)
This document was approved	20 December 2022
This document was ratified by	Executive Management Group
This document was ratified	15 February 2023
An equality analysis was completed on this policy on	20 December 2022
Document type	Public
FOI Clause (Private documents only)	N/A

Change record

Version	Date	Amendment details	Status
V2	Feb 2012	Minor changes re titles of governance groups and job titles	Withdrawn
V2.1	March 2016	Minor changes re titles of governance groups, job titles, inclusion of Health Service Regulation detail and reference as per Clinical Effectiveness Group request.	Withdrawn
V3	February 2018	Minor changes to job titles, inclusion of reference to specific procedures which were updated in the Procedural Manual, and updated policy format including KPIs and TNA.	Withdrawn
V3.1	15 Feb 2023	Full revision with minor changes, including: • Amendments to Governance Groups detailed and job titles updated • Updated to the current policy template • Our Journey to Change text added • 'How the implementation of this policy will be monitored' section has been updated to reflect practice	Ratified

Appendix 1 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	**Scope**
Name of service area/directorate/department	Nursing and Governance
Title	Clinical Audit Policy
Type	Policy
Geographical area covered	All Trust sites and Employees
Aims and objectives	To define systems and processes for consistent operation of clinical audit across Tees, Esk & Wear Valleys NHS Foundation Trust
Start date of Equality Analysis Screening	November 2022
End date of Equality Analysis Screening	20 December 2022

Section 2	**Impacts**
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	The policy benefits the public, service users and carers, health communities and staff operating within the Tees, Esk & Wear Valleys NHS Foundation Trust locality areas.
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO**

	• **Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families **NO**
Describe any negative impacts	None
Describe any positive impacts	The Clinical Audit Policy supports the Trusts services to be accessible to all and respond to diversity.

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	• Feedback from the Care Quality Commission • NICE Guidance • Data collection/analysis • National Guidance/Reports
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	No
If you answered Yes above, describe the engagement and involvement that has taken place	n/a

If you answered No above, describe future plans that you may have to engage and involve people from different groups	This version v3.1 is a minor revision only and future plans will include full trust wide consultation

Section 4	**Training needs**
As part of this equality analysis have any training needs/service needs been identified?	Yes
Describe any training needs for Trust staff	Clinical audit awareness, knowledge and skills development training which particularly focuses on theory and operational delivery of Trust systems and processes has been identified. A range of generic training programmes are to be developed to be accessible to all Trust staff working in both clinical and non-clinical environments. Team Development Days and internal bespoke training sessions are delivered to all members of the Clinical Audit and Effectiveness Team to ensure required skills and competencies to support Trust Clinical Audit and Effectiveness activity.
Describe any training needs for patients	N/A
Describe any training needs for contractors or other outside agencies	N/A

Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes / No / Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2.	**Rationale**		
	Are reasons for development of the document stated?	Y	
3.	**Development Process**		
	Are people involved in the development identified?	Y	
	Has relevant expertise has been sought/used?	Y	
	Is there evidence of consultation with stakeholders and users?	Y	
	Have any related documents or documents that are impacted by this change been identified and updated?	Y	
4.	**Content**		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are supporting documents referenced?	Y	
6.	**Training**		
	Have training needs been considered?	Y	
	Are training needs included in the document?	Y	
7.	**Implementation and monitoring**		

	Title of document being reviewed:	Yes / No / Not applicable	Comments
	Does the document identify how it will be implemented and monitored?	Y	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Y	
	Have Equality and Diversity reviewed and approved the equality analysis?	Y	E&D HC
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Y	EQAIG and Management Group
10.	**Publication**		
	Has the policy been reviewed for harm?	Y	No harm
	Does the document identify whether it is private or public?	Y	Public
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	