Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Clinical Audit Policy

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P073	Clinical Audit and Improvement Manager	Quality and Standards Committee	3 years

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Contents

1. Introduction

Avon and Wiltshire Mental Health Partnership NHS Trust recognises its responsibilities and duties in respect of conducting and managing clinical audit to the benefit of service users, using best practice standards.

A succession of national publications underline the expectation that healthcare professionals participate in clinical audit[1-7].

Clinical audit is an integral part of quality improvement.

An Engagement in Clinical Audit indicator was introduced by the Healthcare Commission in 2008. Its principles are used by the Care Quality Commission to identify good practice in clinical audit. They place an expectation on us to:

- Participate in local and/or national audits of the treatment and outcomes for patients.
- Have a clinical audit strategy and programme related to both local and national priorities with the overall main aim of improving patient outcomes.
- Make available suitable training, awareness and support programmes to clinicians regarding the systems and arrangements for clinical audit.
- Ensure that all relevant staff conducting or managing clinical audits are given appropriate time, knowledge and skills.
- Undertake a formal review of the local and national audit programme to ensure that it meets the organisation's aims and objectives as part of the wider quality improvement agenda.
- Provide the management and governance leads with regular reports on the progress being made in implementing the outcomes of national clinical audits, and review the outcomes, with additional or re-audits where necessary.

In 2008 The Darzi report High Quality Care for All[10] put quality at the heart of its strategy for improving the NHS. Our strategy for this (and subsequent requirements) is set out in the Board Strategy for Quality Improvement (2010-15) and Quality Improvement Strategy 2013-2017. Both include commitments to deliver the Clinical Audit Strategy and consider clinical audit to be a core area of quality improvement.

Under the Health Act 2009, we are required to publish Quality Accounts, which include a statement about involvement in National Audits, actions taken, and a summary of local clinical audit activity.

From April 2011, the NHS Standard Contract requires providers to participate in national audits relevant to their services, and implement recommendations.

From April 2012, the NHS Litigation Authority requires trusts to have approved documentation ensuring audits are carried out in a systematic manner.

From 2012 all doctors who hold a licence to practice must demonstrate to the General Medical Council that they are fit to practice. This includes examples of quality improvement activity which can be effective participation in clinical audit or an equivalent quality improvement exercise that measures care.

2. Purpose or aim

The purpose of this policy is to set out the principles and process for clinical audit within AWP and to set out the framework in support of this.

The policy aims to ensure that that there are effective processes in place to embed a culture of clinical audit best practice, and continuous quality improvement in all services.

The Clinical Audit Strategy 2013-16 sets out the Trust’s vision for the continued development of clinical audit within the Trust.

Failure to implement this policy could impact on the delivery of a high quality service and adversely affect our reputation and the confidence the public has in us. It could also have financial consequences as commissioning contracts require us to demonstrate the quality of care delivered, and that the recommendations arising from clinical audits are reviewed and implemented.

3. Scope

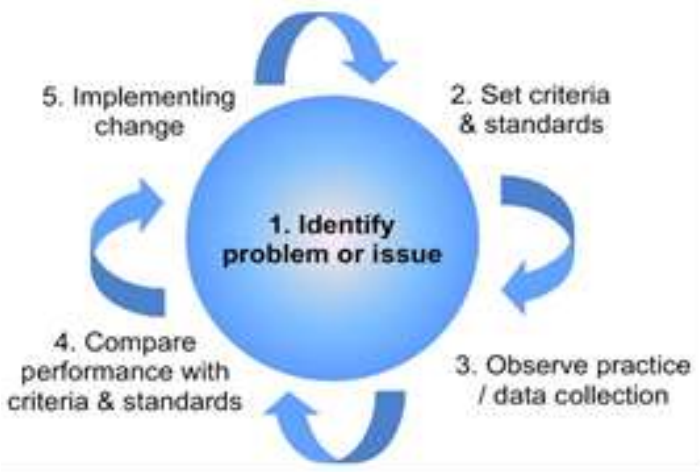
The target audience for this policy are the Board, all clinical and non-clinical staff, managers, professional leads and policy leads; Clinical & Service Directors and those with responsibilities for local and service based governance arrangements.

It applies equally to all services and corporate departments. It also applies when clinical audit is undertaken jointly across organisational boundaries and to all individuals or organisations undertaking clinical audit within AWP, including students, trainees, employees of other agencies and volunteers. We encourage leads to seek the involvement of service users, carers and concerned members of the public, but they should not have access to raw data or service user records.

4. Definitions

We support the definition of clinical audit provided by NICE (2002)[8] and endorsed by the Department of Health (2006)[7].

> *"Clinical audit is 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 re-auditing is used to confirm improvement in health care delivery."*



- **HQIP** Healthcare Quality Improvement Partnership. HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. Its purpose is to promote quality in healthcare, and increase the impact that clinical audit has on healthcare quality in England and Wales.
- **POMH** Royal College of Psychiatrists Prescribing Observatory for Mental Health
- **NCAPOP** National Clinical Audit and Patient Outcomes Programme

5. Policy description

Clinical audits compare current practice to recognised best practice standards. These may be national standards including NICE, ECTAS, Mental Health Legislation Codes of Practice, and clinical policies. The audit lead has final responsibility for selecting appropriate audit standards for the audit. Clinical audit is fundamentally a quality improvement process, but it also has a role in compliance and assurance.

In addition to clinical audit, there are other methods and activities contributing to quality improvement. Examples include service evaluation, inspection, process mapping, surveys, and PDSA cycles. These are beyond the scope of this policy but links between them are maintained through the Quality Academy, and local governance structures. There is an expectation that all quality improvement projects are delivered to the same high standard and comply with the same information governance rules. The Clinical Audit and Improvement Team can support these if requested. If a project has a mixed method which includes clinical audit then it falls under this policy. Further information can be found on the Clinical Audit or Academy pages of Ourspace.

5.1 Clinical Audit must always benefit service users

The following areas should be the focus of clinical audit activity:

- Therapeutic Inputs: diagnosis and treatment of service users, reviewing compliance in relation to therapeutic interventions (pharmacological, psychological, psycho-social and physical care) against evidence-based criteria whether nationally (including NICE Guidance) or locally defined.
- Patient safety topics: examples include safeguarding; risk screening, assessment and management; the management of violence & aggression, control and restraint and seclusion.
- Care environment & facilities: infection prevention & control, medical devices, medicine storage, food & drink, affording service users dignity & respect (Note: the Estates and Facilities Teams and Infection Control Team have audit programmes that are not overseen by the Clinical Audit and Improvement Team).
- Clinical records management: assessment and care planning documentation, clinical record keeping, drug prescription & administration records, quality of letters.
- Mental Health Act; Mental Capacity Act; Consent & Information: processes of consent; the provision of information to service users around access to services, medication & therapies; assuring the rights of detained patients and those lacking capacity.
- Trust policies with regard to clinical care: e.g. the management of patient care pathways, the management of dual disorder, rapid tranquilisation.
- Public Health initiatives: such as smoking, exercise and weight management as well as mental well-being initiatives, suicide prevention.

We recognise that there will be occasions when exceptional circumstances trigger the need for an emergency or urgent audit. In this circumstance it is permissible for the Clinical Audit and Improvement Manager (not the facilitators) to collect data. The team facilitates audits, rather than conducts them, so they do not generally collect data.

We support collaborative multi-professional clinical audits and cross-area, multi-agency and interface audits with primary or secondary care, to ensure the whole care pathway, and any interface issues are addressed. Such projects are complex and require advanced planning and to ensure adequate resource allocation.

The Annual Clinical Audit Work Plan includes participation in national audits set by the National Clinical Audit and Patient Outcomes Programme (NCAPOP); Royal College of Psychiatrists Prescribing Observatory for Mental Health (POMH); audits arising from serious untoward

incidents; audits of policies and audits in relation to professional standards. The work plan needs to balance national, regional and commissioner requirements, with more locally determined needs. The process by which the annual plan is developed and approved must begin well in advance of the start of the financial year.

The Clinical Audit and Improvement Team will send out a general reminder each year to alert Service Delivery Units (SDUs) Policy and Professional Leads of the need to identify specific audit requirements. Clinical and Service Directors are responsible for ensuring that systems are in place to address and monitor the agreed plan, which will include National and Trustwide audits. They are also responsible for ensuring that systems are in place for considering the results of all audits and the subsequent development, implementation and monitoring of action plans.

In the course of the year additional audits may be undertaken and there is some capacity within the work plan to accommodate these. Anyone requesting a clinical audit as an action arising from an investigation is responsible for ensuring this is added to the work plan, and should discuss this with the Clinical Audit and Improvement Manager.

In the course of the year individuals may wish to initiate a clinical audit project on the basis of personal interest, professional development, as part of a training programme or as a revalidation requirement. These must always be in the interests of service users. Where possible they should involve themselves in the existing work plan rather than starting a new project. If a new project is required then there is guidance on Ourspace and the locality Clinical Audit and Improvement Facilitator should be contacted, as arrangements vary between localities.

5.2 Authorisation of audit projects and logging

It is a requirement that all clinical audit projects are authorised and logged by the Clinical Audit and Improvement Team and that authorisation is obtained before starting data collection. This is to ensure that audits comply with standards of good practice, information governance regulations and cover a topic appropriate to clinical audit. Full details of the authorisation process can be found on the Ourspace Clinical Audit pages or by contacting the Clinical Audit & Improvement Manager. Conducting a clinical audit without authorisation is a breach of policy and may result in disciplinary action.

Clinical audit leads will need to consider carefully how the audit sample is to be identified, to ensure it is representative. Audit leads should discuss this with their Clinical Audit and Improvement Facilitator.

All clinical audit projects (except National Audits) should be written up in the approved format (see Clinical Audit pages of OurSpace) which includes an action plan. Guidance on report writing and effective action planning can be found on the same pages. Reports should be written up in a reasonable time. If reports are significantly delayed they may lose their relevance and will be reported to the Quality and Standards Committee as exceptions.

All clinical audits must be risk assessed according to the agreed Trust matrix. This will ensure appropriate escalation of issues and risks via the Trusts quality governance arrangements and to the Quality and Standards Committee as necessary.

Reports in this draft form should be submitted to the Clinical Audit and Improvement Facilitator for review. The draft report should be presented to the relevant Governance Group at the next available meeting. The Governance Group must consider the results, the draft recommendations and actions before agreeing a final action, approved action plan. Where no actions are required, the action plan should state this and not be left blank.

LDUs will then oversee and implement those actions and monitor progress with actions. The same holds for professional groups overseeing audits. Where a Trustwide group is overseeing an action plan, it should liaise with LDU triumvirates to agree local actions. LDUs should similarly incorporate relevant agreed actions from Trustwide or National audits into their plans and monitor progress.

It is good practice to share the results of audits and action plans with all those involved. An audit in one area may be transferable to other parts of the organisation. If a lead or author is planning to present audit findings outside the trust they must seek approval from their relevant Clinical Director, or Governance Group Chair; their Head of Profession and the Heads of any additional professions whose practice they have audited. If audits are not shared with front line staff then change is unlikely to be sustained.

Re-audit. In order to assess whether service improvements have resulted from the actions taken, a number of re-audits will be undertaken. The action plan should identify if and when and if a re-audit will occur.

5.3 Equality and Diversity

All clinical audit activity will be undertaken with regard to the issue of diversity and equality as defined in the Equalities Act. This includes, but is not limited to, the protected characteristics of age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity. Cultural bias should be considered if one profession's practice is audited by another.

5.4 Information Governance

Collection, storage and retention of data and confidentiality. All clinical audit activity must take account of the Data Protection Act (1998) and the Caldicott Principles (1997). This means that data should be:

- Adequate, relevant and not excessive.
- Accurate.
- Processed for limited purposes.
- Held securely.
- Not kept for longer than is necessary.

All staff involved in clinical audit should follow these principles and ensure that patient-related data is collected, stored and reported in a non-identifiable manner. No data should be collected until the audit proposal is approved, or retained after the audit is published. Data collected for audit purposes should be disposed of securely. Data collected for audit purposes is AWP rather than personal property. Where an individual undertaking an audit leaves prior to completion, the data and drafts should be transferred to the new author and the Clinical Audit and Improvement Team informed of alternative arrangements.

When presenting data within a report, it is generally appropriate to display by ward or team. However it is inappropriate to name, or otherwise identify, individual staff within an audit report. The purpose of clinical audit is quality improvement, not performance management.

If an author or group wishes to display findings outside the trust they need additional permission from a senior person, usually a clinical director, Head of Professions and Practice, Director or Lead.

Final reports are placed on the Clinical Audit pages of OurSpace. These pages are maintained and remain available on these pages for a five year period in line with Records Management: NHS Code of Practice (DH 2006). Changes will be made by the Clinical Audit and Improvement Team to update the action plans but not otherwise change the contents of the reports.

The Trust has an Information Risk Policy in place which staff should refer to covering additional rules.

5.5 Confidentiality Agreements

Where the Trust engages individuals in its clinical audit activities who are not directly employed by the Trust or when access to AWP data/patient files is requested by external organisations for audit purposes, it is essential to ensure they understand the rules that apply. In such instances, it is essential that this is agreed with the Clinical Audit and Improvement Manager and advice is sought from HR, Caldicott Guardian and/or Medical Records Department and all necessary safeguards addressed. This will usually include signing a confidentiality statement.

5.6 Service User and Carer Involvement

We are committed to involving service users/carers in the clinical audit and quality improvement processes. This will include asking SDUs to consider service user complaints, suggestions and feedback when selecting topics and attendance at service user and carer groups by audit facilitators. We promote a culture of openness and share audit results with service user and carer groups, and take audit topic suggestions from these groups.

6. Roles and responsibilities

6.1 Chief Executive

The Chief Executive has overall responsibility for the quality of services being delivered.

6.2 Director of Nursing and Quality

The Director of Nursing and Quality is the executive/board lead for clinical audit, and ensure the clinical audit strategy, policy, and annual work plans align with the Board's strategic interest and concerns. The Director also ensures audit is undertaken in line with this policy across the Trust, and adequate time and resource are available to ensure completion of the work plan. This Director line manages the Clinical Directors who have responsibility for the completion of their audit work plans and actions.

6.3 Clinical Executive

The Clinical Executive (the Director of Nursing and Quality and the Medical Director) has executive responsibility for clinical quality The Medical Director oversees medical appraisal and revalidation processes.

6.4 Director of Operations

The Director of Operations has responsibility for overseeing the Service Directors for each Locality and Specialism.

6.5 Quality & Standards Committee

The Trust Quality & Standards Committee (a sub-committee of the Board) has ultimate responsibility for final approval of the work plan and for ensuring SDUs engage. It receives regular progress updates.

6.6 Clinical and Service Directors

The Clinical & Service Directors are jointly responsible for:

- Developing and agreeing their locality audit work plan.
- Ensuring that audit activity within their service is registered.
- That their services participate in national and priority audits.
- Actions and learning arising from audits are completed appropriately, and built into their business plans where the need arises.

- They may choose to delegate some or all of their overall responsibility to a named clinician as Audit Lead. Where this is the case, it is essential that the individual concerned has protected time for the role.
- The Clinical Audit and Improvement Team should be formally notified of precise arrangements in this respect and a mutually agreed process put in place for regular review of the arrangement.
- Directors (or their Audit Lead) will provide the Clinical Audit and Improvement Team with the names of nominated Leads for individual clinical audits on their work plans. These leads will liaise with the facilitators in relation to individual audit projects.

6.7 Clinical Audit and Improvement Team

The Clinical Audit and Improvement Team works collaboratively with SDUs, Policy Leads/Authors, Heads of Professions and individual clinicians in support of the delivery of the Annual Clinical Audit Work Plan. This support includes working with staff/audit leads on the development of audit proposals and audit tools, identifying standards, assistance with data analysis and developing a skeleton audit report. The team facilitates rather than conducts audits does not collect data (see 5.5 for the exception to this rule).

6.8 All staff

All AWP staff have a responsibility for the quality of the service they provide and are expected to engage in clinical audit when required. Participation in clinical audit should be included in job descriptions. If clinical audit is a requirement for revalidation or as part of a professional code of conduct they should request this in a timely way to ensure the effective allocation of resources.

6.9 Trainees

Where a trainee proposes to undertake a clinical audit, we require it to be first approved by their supervisor, who undertakes to complete that project if the trainee moves post prior to completion.

6.10 Managers

Although we acknowledge that clinical and service managers will not necessarily undertake clinical audit, they are expected to play a pivotal role in the overall audit process by involvement in the identification of appropriate topics, ensuring staff participate in, and have adequate time to undertake audit, being aware of the results of audits relevant to their service and by ensuring the development and implementation of action plans. We expect all teams/wards to participate in clinical audits as it benefits their service users.

7. Training

We recognise that effective clinical audit relies on staff having the appropriate knowledge and skills. For details of the training dates and eLearning please see the Clinical Audit Training page on OurSpace, or contact the Clinical Audit and Improvement Team.

8. Monitoring or audit

The Clinical Audit and Improvement Team will monitor the progress of clinical audit programmes and outcomes through quarterly monitoring process and an Annual Clinical Audit Report. The effectiveness of this policy will be overseen by the Quality Academy. The team will maintain an on-going record of progress against all actions plans but is not responsible for them. We will, through the annual report and updates to Quality and Standards Committee monitor the following:

- Duties related to clinical audit.

- Process for setting priorities for a clinical audit programme.
- Monitoring participation national clinical audits.
- Process for ensuring appropriate standards of performance are audited.
- Process for disseminating audit results/reports.
- Process for making improvements.
- Process for monitoring action plans and carrying out re-audits.
- Monitoring risks identified through audit findings.

9. References

Department of Health (1989) Working for Patients

Department of Health (1997) The New NHS — Modern, Dependable

Department of Health (1998) A First Class Service

Department of Health (1999) Clinical Governance in the new NHS — Quality in the NHS

Department of Health (2002) 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 (2004) National Standards, Local Action: Health and Social Care Standards and Planning Framework

Department of Health (2006) Good Doctors Safer Patients

National Institute for Clinical Excellence (2002) Principles for Best Practice in Clinical Audit Radcliffe Medical Press

Department of Health (2007) Trust, Assurance & Safety

Department of Health (2008) The NHS Next Stage Review Final Report: High Quality Care For All (Darzi)

General Medical Council (2011) 2012 Ready for Revalidation: The Good Medical Practice Framework for Appraisal and Revalidation

Brain et al (2009) A Guide for Clinical Audit, Research and Service Review HQIP (PRINT)

10. Appendices

10.1 Appendix 1 Prioritisation of Clinical Audit Projects

The Trust should have a framework to support effective clinical audit that relies on strategic planning and prioritisation. Audit projects should contribute to the overall priorities of the organisation and be clear about how patient care will be improved.

However, resources are finite; both in terms of clinician time and central support function resource and this places a limit on the number of audits that can be carried out over the course of a year. This means that when all the various sources have been considered, the topics suggested need to be prioritised in a systematic way.

A clear approach has been agreed for the development of the clinical audit programme and its local application. Below is a 4-step prioritisation model. The process of prioritisation used in this model assumes a hierarchy of importance, with priority one being the most important. The first three priorities contribute to the bulk of the annual clinical audit programme. The fourth relies on the availability of local resources over and above those required to deliver the first three priorities and this will vary between service delivery units.

Priority 1 — External 'must do' audits

It is essential to ensure that externally monitored audits that are driven by commissioning and quality improvement are treated as the priority and that appropriate resources are provided to support these. Failure to participate or deliver on these externally driven audits may carry a penalty for the Trust (either financial or in the form of a failed target or non-compliance — hence "must-do" audits). These are externally monitored and assessed by the CQC (Care Quality Commission) and in some areas by the local PCT (Primary Care Trust) commissioner. The annual clinical audit forward plan should be determined at directorate /division/service Level.

Example topics to include at this priority should be:

- New national targets and existing commitments
- POMH (Prescribing Observatory for Mental health) R C Psychiatrists
- ECTAS Audits (ECT Accreditation)
- NCAPOP (National Clinical Audit and Patient Outcomes Programme)
- Audits demonstrating compliance with regulation requirements e.g. audits with the aim of providing evidence of implementation of NICE technology appraisals, clinical guidelines and public health guidance and other national guidance such as that coming from NPSA (National Patient Safety Agency Alerts)
- Regional CQUINS (Commissioning for Quality and Innovation) and other commissioner priorities
- NHSLA (National Health Service Litigation Authority)
- DH statutory requirements, such as infection control monitoring
- Re-audits of any of the above

Priority 2 — Internal 'must do' audits

In addition to national clinical audit topics, the choice of further topics should be based on the classic criteria of high risk or high profile identified by the Trust clinical audit strategy. They may include national initiatives with Trust-wide relevance but no penalties exist for non-participation. Many of these projects will emanate from Trust governance issues or high profile local initiatives and will include:

- Priorities reflective of organisational objectives for clinical audit as outlined in local clinical audit strategy
- Clinical risk issues
- Serious untoward incidents/adverse incidents
- Organisational clinical priorities
- Priorities identified via Patient and Public Involvement initiatives
- Complaints
- Access
- Patient Safety First Campaign
- Re-audits of any of the above.

Priority 3 — Directorate priorities

SBU's (Strategic Business Units) are required to submit projects that are priority pieces of work and important to them – local priorities. They may include DH initiatives and be SBU specific but no penalties exist for non-participation. Directorate priorities may include:

- Local clinical interest audit agreed by the SBU as a priority
- National audits not part of NCAPOP, e.g. some Royal College initiated projects lie outside of NCAPOP
- Locally adopted clinical standards benchmarking e.g., Essence of Care
- Re-audits of any of the above.

Priority 4 — Clinician interest

Some of these projects registered later in the year will slot into one of the above categories. However, there will be a number of projects that will not fall into any of the above priorities. It is fully recognised that there is a need to maintain a degree of locally initiated projects. These projects often cannot be determined at the outset of the financial year. They represent innovative ideas from clinicians and can provide valuable educational experience for junior staff. The annual Trust clinical audit programme will be regularly updated to reflect this.

Quality impact analysis

When prioritising "clinician interest" clinical audits, Quality Impact Analysis (QIA), as stated in Principles for Best Practice, may be used by the SDUs. This allows requested topics for clinical audit need to be prioritised in a systematic way. This will be done by ranking topics in order of importance, such as a QIA. This allows for the use of questions to help determine priorities among topics for audit.

The following criteria will be applied.

- High frequency/volume of service — most frequent reasons for referral, admission or treatment or most frequent procedures performed
- High risk — services or aspects of services with higher than average risk potential to staff or patients, due either to the nature of the treatment or procedure or the potential risk if the service is delivered inappropriately
- High cost — aspects of a service that involve higher than average costs or which could involve high costs if not provided properly
- Potential for change — the anticipated potential for change arising from the project with the support of those individuals who can effect change
- Existence of evidence-based guidelines/standards – the level by which the project is comparing current practice against evidence based practice/guidelines

- Direct impact on patients — a judgement based on the anticipated outcomes of the project, taking into account direct patient benefit
- Direct involvement with patients/families — does the project directly include patients or families?
- Multidisciplinary project — the level of involvement between different disciplines
- Multiagency project — the level of involvement at the interface between AWP and other NHS establishments or organisations.

Version History

Version	Date	Revision description	Editor	Status
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1.1	17 June 2010	Amendment re confidentiality agreement	Head of Quality & Effectiveness	Approved
2.0	10 May 2011	To Quality & Healthcare Governance Committee	Head of Quality & Effectiveness	Approved
2.1	31 December 2012	Administrative changes and some re-ordering and re-numbering of paragraphs to aid clarity	Head of Quality & Effectiveness	Approved
2.2	October 2015	Full review undertaken	SJ	Draft
2.3	17 November 2015	Submitted to Quality and Standards Committee for approval	SJ	Draft
3.0	17 November 2015	Approved by Quality and Standards Committee	HD	Approved
3.0	03 December 2018	Marked as under review	JW	
3.1	3 September 2019	Extended until March 2020	JK Nursing Director	Approved