CLINICAL EFFECTIVENESS AND AUDIT STRATEGY, 2012 - 2017

Amendments

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<td>• inclusion of Clinical Service Development Group (CSDG)</td>
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<td>• Strong links to Quality, Safety &amp; Risk Management Strategy and Trust strategic objectives.</td>
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<td>App 3</td>
<td>• Revised focus on national priorities; change of CEAG to Clinical Effectiveness and National Audit Review Group, CENARG; general updates, titles, divisions</td>
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<td>App 4</td>
<td>• Clinical audit projects divisional monitoring plan</td>
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<td>• End of year clinical audit reporting template</td>
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Compiled by: Head of Clinical Effectiveness

Ratified by: Management Board, Executive Group / Quality Governance Committee (April 2014)

Date Issued: April 2014

Next Review Date: March 2017

Target Audience: All Clinical Staff

Contact Name for Comments: Ann Spiropoulos, Head of Clinical Effectiveness
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3 Aims and Goals

4 Objectives

5 Annual Priorities and Targets

6 Conclusion

7 Strategy Review

References

Appendices

1. CENARG Terms of Reference (January 2014)
2. Trust Clinical Audit Forward Plan Outline, Divisional Monitoring Plan Outline and End of Year Reporting Template
3. Clinical Audit Project Guidelines including guidance from HQIP
4. Standard forms and templates
CLINICAL EFFECTIVENESS AND AUDIT STRATEGY 2012-2017

See also:

- The Quality, Safety and Risk Management Strategy
- National Guidance Monitoring Framework
- Interventional Procedures Policy

*This strategy does not encompass specific aspects of research. (For information relating to research refer to the “Research Framework”).*

**Vision:**

To lead and enable Trust-wide commitment to continuous progression in clinical effectiveness and professional development with the aim of improving patient care.

**Executive Summary**

Clinical effectiveness and clinical audit are central to the delivery of the clinical governance agenda, supporting continuous improvement in patient care and continuous professional development.

This document sets out the strategy for clinical effectiveness and audit for Ashford and St. Peter’s Hospitals NHS Foundation Trust. This strategy underpins the Trust Quality, Safety & Risk Management Strategy and aligns with the Trust vision and strategic objectives. The Trust values, the ‘4Ps’ are emphasised together with the priorities and processes for continuous development of clinical effectiveness and audit within the Trust.

The strategy outlines three main goals of commitment, communication and coordination and recommends nine main objectives to achieve these goals:

1. Establish commitment
2. Promote clinical effectiveness and audit
3. Establish formal communication and reporting processes
4. Achieve centralised strategic direction
5. Achieve focus on quality of clinical audit
6. Implement a planned clinical audit programme that responds to national and local priorities
7. Encourage involvement of patients and the public
8. Implement effective education and training programmes
9. Monitor and evaluate processes, systems and mechanisms

These objectives are translated into action with criteria for successful implementation proposed.

It is essential that each area takes responsibility for their own programme of clinical audit and effectiveness and that this is securely linked to the trust clinical governance agenda and key trust objectives. Division, specialty and senior management commitment and strong communication links with the Clinical Effectiveness and National Audit Review Group and the Trust Quality Governance Committee are essential for success of this strategy.
1 INTRODUCTION

1.1 Clinical Governance

Organizations must safeguard high standards of care by creating an environment in which excellence in clinical care will thrive. Lord Darzi’s report “High Quality Care for All” (Department of Health, 2008), identified the focus on quality of healthcare for patients across the NHS. The final report of Lord Darzi’s NHS Next Stage Review sets a new foundation for a health service that empowers staff and gives patients choice with quality at its heart.

In 2009, the Department of Health established the National Quality Board (NQB) bringing the Department of Health, the Care Quality Commission (CQC), Monitor, the National Institute for Health and Care Excellence (NICE) and the National Patient Safety Agency (NPSA) together to look at the risks and opportunities for quality and safety across the whole health system.

Clinical effectiveness and clinical audit are essential components of the clinical governance agenda to improve and assure quality; there are close links to the other main elements of quality: patient safety and patient experience. (Quality in the New Health System – maintaining and improving quality from April 2013, National Quality Board, Final Report, 2013).

In 2012, the Trust conducted a gap analysis of its current position against the principles set out in the Quality Governance Framework (Monitor, 2010) and developed a Quality, Safety and Risk Management Strategy. The main elements of change are:

- Divisional ownership of quality and risk management structures and committees
- Strengthened processes for assessing and monitoring compliance with essential standards and national guidelines
- Formulated reporting mechanisms and measures of effectiveness around risk management
- Improved patient engagement and involvement strategies

This strategy supports the Quality, Safety and Risk Management Strategy and should be read in conjunction with strategies for patient safety and patient experience.
1.2 The Trust Vision

The vision of the organisation is to be one of the best healthcare Trusts in the country; this vision is underpinned by the values of the Trust, the ‘4Ps’:

- Patients First
- Personal Responsibility
- Pride in our Team
- Passion for Excellence

The diagram below shows how the Trust’s values align to the NQB’s Quality Governance Framework and depicts the Trust’s strategic vision for Quality.

1.3 Clinical Effectiveness

Clinical effectiveness is the process of making clinical practice more explicitly evidence based to improve patient care, clinical practice and service delivery. There is a requirement for continuous review of clinical practice and use of evidence-based best practice in healthcare decision making. Evidence-based best practice includes local and national guidance.

The National Guidance Monitoring Framework was developed to manage all national guidance: National Service Frameworks, NICE guidance (National Institute for Health and Care Excellence), the confidential enquiries and other accredited national studies and ensure that there is:

- Distribution to all appropriate personnel
- Gap analysis and risk assessment
- Monitoring of implementation
• Recording of progress and improvements to services.

1.4 Clinical Audit

From Principles for Best Practice in Clinical Audit (NICE, 2002)

“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 further monitoring is used to confirm improvement in healthcare delivery”.

The five stages of clinical audit are identified as:

• preparing for audit;
• selecting criteria;
• measuring performance;
• making improvements and
• sustaining improvements.

The Department of Health in various published documents identifies an expectation that all healthcare professionals including nurses, doctors, therapists and other members of the healthcare team take part in clinical audit.

The Trust established the Clinical Effectiveness and Audit Committee, CEAC (now termed CENARG, Clinical Effectiveness & National Audit Review Group with a changed emphasis on national audit and Trust priorities) on the merger of Ashford and St Peter’s Hospitals in 1998. (For the latest Terms of Reference refer to the annual report for the group; Appendix 1 contains TOR dated January 2014).

1.5 Roles and Responsibilities

The Trust strategy for clinical effectiveness and clinical audit is co-ordinated by the Head of Clinical Effectiveness, who reports to the Deputy Medical Director.

The Head of Clinical Effectiveness (HCE):

1. Acts as Secretary to CENARG
2. Acts as the NCEPOD (National Confidential Enquiries into Patient Outcome and Death) Local Reporter
3. Prepares the Trust Clinical Audit Forward Plan (Appendix 2) and annual submission to the Quality Governance Committee (QGC) in liaison with the CENARG Chair and members
4. Produces regular reports for CENARG, adhoc reports to areas; provides information for the annual Quality Account and collates evidence required by monitoring and inspection bodies relating to clinical effectiveness and audit
5. Provides advice, guidance, training and support to divisions
6. Networks with colleagues in other organisations

The Clinical Effectiveness and National Audit Review Group, CENARG, has membership from the Divisions and is responsible for:
1. Development and monitoring of the annual Trust Clinical Audit Forward Plan
2. Review of policies and strategies relating to clinical effectiveness and audit
3. Divisional representatives support development of their local audit programmes ensuring that these align with Trust priorities
4. Divisional representatives maintain details of clinical audit activity within their area and receive and store reports and actions plans on completion of studies
5. Divisions should identify their key priority audits before the beginning of the financial year and should incorporate audit completion controls into rotation handovers and junior doctor competency sign-offs.

CENARG links closely and reports to the Trust Quality Governance Committee, QGC.

Some areas have established posts for clinical audit. These staff are responsible to, and report to, the specific area.

2  STAKEHOLDERS

- Clinical staff from all disciplines and at all levels across the Trust
- Patients receiving care from the Trust and their carers and families
- Commissioning bodies
- Relevant local community and voluntary bodies
- The catchment population who may access services in the future

3  AIMS AND GOALS

The strategy links to the Trust’s key, clinical, quality improvement objectives, including national and local priorities. The strategy supports areas to ensure that clinical care within the Trust is firmly evidence-based and to demonstrate that clinical practice is effective, appropriate and of high quality and will enable areas to further develop and strengthen their own clinical effectiveness programmes.

Strategic aims will be addressed through achievement of three goals:

- Commitment (personal responsibility, pride in our team): identifying champions and leaders to motivate and gain and maintain commitment to a continuous process of quality enhancement;
- Communication (patients first, personal responsibility): identifying and communicating priorities for clinical effectiveness and clinical audit, promoting clinical effectiveness and audit, networking to enable feedback, sharing and learning;
- Coordination (passion for excellence): providing direction; delivering advice, support and training; developing tools and reference materials; developing systems and mechanisms to collate evidence; provision of reports.
4 OBJECTIVES

To achieve the aims and goals the following high-level objectives provide a template to guide development of clinical effectiveness and audit and measures for monitoring are suggested.

COMMITMENT (Personal Responsibility, Pride in our Team)

1. Establish Commitment

Develop commitment from Trust Board level (top down) and commitment from individual levels at grass roots (bottom up) aiming to establish robust commitment at division level to initiate and support clinical effectiveness and clinical audit activities within and across professional and organisational boundaries.

Success criteria – attendance at CENARG, increased involvement of key workers and champions in areas of audit and effectiveness e.g. using numbers of audit projects per area, linking across boundaries, providing feedback relating to NICE guidance and other national priorities.

COMMUNICATION (Patients First, Personal Responsibility)

2. Promote clinical effectiveness and audit

Develop mechanisms for promotion of clinical audit and clinical effectiveness across the Trust:

- encourage participation in multidisciplinary clinical audit as part of routine clinical practice,
- maintain awareness of the clinical effectiveness and audit agenda by publicising relevant articles and reports,
- identify and share information and results on audit and good practice,
- increase awareness of resources available to facilitate audit

Success criteria – List of promotion activities and resources e.g. attendance at internal and external meetings, emails, newsletters, posters, presentations, clinical audit website

3. Develop communication and reporting processes

Develop and establish formal communication links to enable co-ordination of the clinical effectiveness and audit strategy via:

- Clinical divisions, specialties and departments via quality teams within areas
- CENARG and QGC
- Associate Director of Quality and Heads of: Clinical Quality Improvement, Patient Safety, Patient Engagement & Experience, Accreditation & Regulation

Provide an annual report and other reports as requested to QGC from CENARG.

Develop and maintain communication with commissioning bodies and with other health economy partners and organisations.
Success Criteria – CENARG annual report, CENARG minutes, other reports and information e.g. audit reports, NICE guidance reports.

COORDINATION (Pride in Our Team, Passion for Excellence)

4. Achieve strategic control

Develop an appropriate infrastructure to support clinical audit and clinical effectiveness across the Trust. This resource will include divisional staff with a remit for clinical effectiveness and advice from the Head of Clinical Effectiveness.

Divisional staff will develop clinical effectiveness programmes within their areas and provide details to enable production of the annual Trust Clinical Audit Forward Plan.

Close links will be established between divisions, via the quality teams within the areas and the Head of Clinical Effectiveness and the Corporate Lead for Quality. Information relating to clinical standards and guidelines should be made available, dissemination and feedback relating to implementation should be coordinated.

Links with Information Services should be maintained to enable access to data stored on hospital IT systems.

Effective systems should be established to record and monitor clinical effectiveness and audit activity see appendix 4 for standard reports and templates.

Success Criteria – Trust Clinical Audit Forward Plan, attendance at CENARG, increased involvement of key workers and champions in areas of audit and effectiveness e.g. using numbers of audit projects per area; linking across boundaries; providing feedback relating to NICE guidance and other national priorities.

5. Implement a planned clinical audit programme that responds to national and local priorities

Identify and prepare the Trust Annual Clinical Audit Forward Plan including key national, regional and local priorities. Include Trust priorities relating to patient safety, patient experience and improving clinical practice (see Appendix 2).

Undertake national, regional and local clinical audit and utilize results and recommendations to inform changes to clinical practice to improve patient care. Incorporate re-audit into clinical audit programmes to confirm improvements and / or identify the need for further action.

Success Criteria – Production of an annual Trust Forward plan and divisional audit plans that are regularly monitored and updated.

6. Achieve focus on quality of clinical audit

Develop information and tools to support good, quality clinical audit including the use of good, quality criteria (see Appendices 3 and 4)

Provide awareness, advice, guidance, support and training
Develop mechanisms for review of clinical audit projects,

**Success Criteria** – Trust Annual Clinical Audit Forward Plan and annual report from CENARG, tools and information, provision of guidance and training, other reports to QGC and Trust Board.

7. **Encourage involvement of patients and carers**

Services must be developed that are designed from the patient’s perspective and which foster a genuine partnership between professionals and the people they serve.

All clinical areas should engage with the patients and public who use their services; this can be supported through the Head of Patient Engagement & Experience, the Trust Patient Panel and governors.

**Success Criteria** – numbers of studies including patient and public involvement and the nature of the involvement e.g. patient surveys, involvement of patient groups in prioritising studies

8. **Implement effective education and training programmes**

Clinical Effectiveness and clinical audit must be high on each Division’s agenda to maintain improvements in quality of care. Training and education in clinical effectiveness and audit are paramount to fostering a culture embracing continuous professional development and continuous quality improvement.

Training and education should be developed by the HCE in collaboration with the Training Department, Clinical Practice Educators, the Health Sciences Library and outside agencies as appropriate.

A variety of education and training programmes for clinical audit and clinical effectiveness should be provided.

**Success Criteria** – record of training and educational information provided

9. **Monitor and evaluate processes, systems and mechanisms**

Establish success criteria / a set of measures to evaluate the effectiveness of the 8 objectives identified; these are included with each objective above.

5 **ANNUAL PRIORITIES AND TARGETS**

All of the components of the Strategy are highly important but annual targets and priorities need to be realistic in accordance with available resources and in response to the Trust key priorities and objectives relating to clinical effectiveness and audit.

Key targets include those identified by the Department of Health, the Care Quality Commission and other standards identified for inspection.

National audit priorities are identified by the Healthcare Quality Improvement Partnership (HQIP, [www.hqip.org.uk](http://www.hqip.org.uk)) in the National Clinical Audit and Patient Outcomes Programme (NCAPOP).
Local priorities should align with Trust objectives relating to patient safety, patient experience and improving clinical practice. See the outline of the Trust Clinical Audit Forward Plan (Appendix 2)

6 CONCLUSION

This strategy identifies the priorities and processes for continuous development of clinical effectiveness and clinical audit within the Trust and aligns with the Trust values, the ‘4Ps’.

Staff are encouraged to undertake regular review of clinical practice and review of new clinical guidance with implementation of changes to clinical practice as appropriate (Patients First, Personal Responsibility).

There is focus on Trust priorities for clinical audit and the quality of clinical audit projects using established standards and criteria (Passion for Excellence).

Appropriate involvement of patients / users is encouraged and supported and aligns with government strategy for a ‘patient-led NHS’ (Patients First).

Resources are essential to deliver advice, support, education and training and collate evidence of improvements in clinical practice and patient care necessary for contracts with commissioning bodies and for inspection purposes (Pride in Our Team).

Sustained improvement in clinical effectiveness involves a partnership between clinicians, patients and managers. It is essential that each clinical area takes responsibility for their own programme of clinical audit and effectiveness and that this is an integral part of their clinical governance agenda. Divisions may employ their own clinical governance and audit staff; each division has a quality team to support the key Trust priorities. All clinical areas are advised to develop and maintain close collaboration with their quality teams and via CENARG membership.

7 STRATEGY REVIEW

Maintaining and improving quality is a dynamic process. The Clinical Effectiveness and Audit Strategy will be reviewed in line with review of the Trust Quality, Safety and Risk Management Strategy or earlier as required.

References


NHS Litigation Authority NHSLA Risk Management Standards London: NHS Litigation Authority


Websites:

www.hqip.org.uk
www.monitor-nhsft.gov.uk
www.nhsla.com
www.nice.org.uk
Clinical Effectiveness and Audit Strategy

APPENDICES
### Appendix 1

**CLINICAL EFFECTIVENESS AND NATIONAL AUDIT REVIEW GROUP (CENARG) TERMS OF REFERENCE (January 2014)**

<table>
<thead>
<tr>
<th><strong>Clinical Effectiveness and National Audit Review Group, CENARG</strong></th>
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<tr>
<td><strong>Constitution</strong></td>
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<tr>
<td>The Quality Governance Committee hereby resolves to establish a sub-committee to be known as the Clinical Effectiveness and National Audit Review Group, CENARG.</td>
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<tr>
<td><strong>Authority</strong></td>
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<tr>
<td>The Clinical Effectiveness and National Audit Review Group is authorized by the Quality Governance Committee to lead, support and report on activities related to clinical effectiveness and clinical audit undertaken in all areas across the Trust.</td>
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<tr>
<td><strong>Membership</strong></td>
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<tr>
<td>1. Chair</td>
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<td>2. Deputy Medical Director &amp; Chief of Patient Safety</td>
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<td>3. Head of Clinical Effectiveness (Secretary)</td>
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<td>4. Corporate Lead for Quality Improvement</td>
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<td>5. Quality Governance Managers / Division Quality Leads</td>
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<td>6. Clinical Leads for clinical effectiveness and audit</td>
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<td>7. Patient Representative</td>
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<td>8. Deputy Library &amp; Knowledge Services Manager</td>
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<td>9. Co-opted members as necessary e.g. Head of Patient Safety, Head of Information.</td>
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<tr>
<td><strong>Attendance</strong></td>
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<td>Members should achieve a minimum attendance of 4 out of 6 meetings annually and send a representative if unable to attend. Note that shared attendance arrangements are acceptable.</td>
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<td><strong>Quorum</strong></td>
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<td>Six members including the Chair or Deputy Medical Director &amp; Chief of Patient Safety shall form quorum for the group.</td>
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<td><strong>Frequency and Conduct</strong></td>
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<td>Meetings shall be held every two months with duration of up to two hours. Items for the agenda should be submitted to the Secretary a minimum of seven working days prior to the meeting.</td>
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<td>Terms of reference will only be changed with the approval of the Quality Governance Committee (QGC); CENARG will review the TOR annually.</td>
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<td>The Chair will be a consultant or other suitable professional employed by the Trust. The Chair of the QGC in consultation with the CENARG Secretary will nominate the Chair of CENARG. The term of office of the CENARG Chair will be two years with an option to extend for a second term with mutual agreement of the QGC Chair and CENARG Secretary.</td>
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Secretary The Head of Clinical Effectiveness will be the Secretary to the Committee.

**Duties**

1. Make recommendations to the Quality Governance Committee / Trust Board relating to:
   - participation in national priorities relating to clinical effectiveness e.g. national audits, confidential enquiries, NICE guidance and quality standards and other appropriate publications e.g. from the Department of Health, Care Quality Commission, Health Care Service Ombudsman
   - Risks and resource pressures affecting achievement of key assurance targets for clinical effectiveness and national audit
   - Reports from quality improvement projects e.g. Enhancing Quality
2. Provide advice to divisions on Trust key priorities relating to clinical effectiveness and audit
3. Monitor the divisional review of recommendations from key national priorities and publications and implementation of change programmes to improve clinical practice and patient outcomes
4. Receive information from divisions on key priority national projects to:
   - Approve inclusion in the Trust forward clinical audit programme
   - Monitor progress of key projects through to their completion
   - Review responses to each national report and enable inclusion in the CENARG annual report and key Trust publications e.g. Quality Accounts
5. Monitor the measures identified in the clinical effectiveness and audit strategy.
6. Review relevant policies for clinical effectiveness and national guidance
7. Divisions are responsible for:
   - Reviewing reports and recommendations from key national and local audit priorities and implementing actions to improve patient care and experience
   - Registering all clinical audits in their areas
   - Delivering final reports on progress with implementation of actions, changes to practice to enable sign-off by CENARG/ QGC
   - Identifying areas where there is a need for education and training relating to clinical effectiveness and audit.
   - Identifying issues relating to successful achievement of Trust key priorities

**Key Responsibilities**

The main objectives of CENARG are:

- Give assurance to the Trust Board regarding the clinical effectiveness and audit agenda internally and in relation to other comparable Trusts
- Lead and support review, analyses and implementation of the recommendations from national enquiries, audits and programmes to improve patient care and outcomes
- Monitor implementation of the Trust strategy for clinical effectiveness and audit including identification of key priorities and compliance with key standards and targets
- To communicate relevant issues to and from divisions and to QGC.

**Reporting Lines**

The Clinical Effectiveness and National Audit Review Group, CENARG, is accountable to the Trust Board through the Quality Governance Committee (QGC).

The minutes of all CENARG meetings shall be formally recorded and archived. The minutes shall be circulated to CENARG members.
Appendix 2

TRUST CLINICAL AUDIT FORWARD PLAN OUTLINE

*Note that this is a working document subject to regular update and review – to access the current plan contact Head of Clinical Effectiveness or CENARG representatives*

**NATIONAL AUDITS**

National audits include continuous data submission and sampling audits.

**HQIP National Clinical Audit and Patients’ Outcomes Programme** (NCAPOP)

**CEM** (College of Emergency Medicine formerly BAEM, British Association of Accident and Emergency Medicine)

**CONFIDENTIAL ENQUIRIES**

**NCEPOD** (National Confidential Enquiry into Patient Outcome and Death)

**MBRRACE-UK** (Confidential Enquiry into Maternal and Child Health formerly CEMACH, CMACE)

**CISH** (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness)

**Royal College of Physicians (RCP)**

**National Blood Service (and RCP)**

**TARN** (Trauma, Audit and Research Network)

**Other National and Regional Audits**

Audits relating to NSFs
National NHS Patient and Staff Surveys
Enhancing Quality Programme

**TRUST PRIORITIES**

For example: Infection Control, Patient safety and risk management, NICE guidance, National recommendations, Peer review, Nursing priorities / Essence of Care

**DIVISION PRIORITIES**

Each division will identify their own forward plans and provide progress to CENARG with results of key audits included in their submission to QGC and produce an end of year report for inclusion in the CENARG annual report.
For further advice on appropriate clinical audit, patient and staff surveys contact the Head of Clinical Effectiveness. All studies, surveys and clinical audits must be registered within the division and regular monitoring and updates provided to CENARG.
Clinical Audit Projects Divisional Monitoring Plan

The divisional clinical audit monitoring plan contains details of each audit project and survey within that division and is located in the CENARG folder on a shared drive (Teams, T:\ drive). The following fields are populated:

- Specialty / area name
- Audit title
- Number of patients included in the study
- Name of audit lead
- Start and end dates OR frequency: monthly, quarterly, 6 monthly, continuous
- Status of project: planning, ongoing, completed
- Date report received + hyperlink to report located in CENARG folder
- Action plan date + hyperlink to action plan located in CENARG folder
- Re-audit required; if Yes update with date when completed + hyperlink
- Comments

Note: where this is a frequently occurring audit no need to complete re-audit details but the frequency should be recorded and reports and action plan links maintained and updated.

Copies of the audit reports and action plans are placed in the CENARG folder within the relevant division folder.

Clinical Audit Projects End of Year Reporting Template

DIVISION Name

- *include frequency if appropriate i.e. monthly, quarterly, 6 monthly audit*
- *highlight any re-audits*

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<thead>
<tr>
<th>Area / Specialty</th>
<th>Audit title</th>
<th>Outcome / Actions / Comments</th>
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Notes:

- *include any other relevant comments*
- *for further details contact:*

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Appendix 3

CLINICAL AUDIT PROJECT GUIDELINES

It is the responsibility of divisions to register and approve all clinical audit projects and patients and staff surveys undertaken within their area. Each Division should identify their key clinical audits in their annual Clinical Audit Forward Plan and produce an end of year report. Further Trust priorities will be approved by CENARG members and QGC. In order to prioritise local audit projects, the following criteria have been agreed:

1. Projects must have the support of one or more of the following:
   - Line Manager, Clinical Director
   - Clinical Effectiveness and National Audit Review Group (CENARG) Representative
   - Consultant, Professional Head

2. Projects should:
   - Aim to be multi-professional
   - Aim to change or improve the quality of patient care and/or clinical practice
   - Be considered achievable and worthwhile for the Trust
   - Be in line with national, regional, local or Trust initiatives
   - Identify patient/user involvement
   - Maintain patient confidentiality at all times

3. Audits must relate to at least one of the following:
   - Patient safety and clinical risk management
   - National and local guidelines, evidence-based clinical practice
   - Priorities for clinical performance and clinical effectiveness (key targets relating to inspection and/or commissioning)
   - Patient experience, patient-focused priorities
   - Closing the audit loop

HQIP - Clinical Audit Programme Guidance Tools

Quality Impact Analysis

One way to prioritise clinician interest projects is to use some form of Quality Impact Analysis (QIA). It has been stated in Principles for Best Practice that topics for clinical audit need to be prioritised in a systematic way. This could 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. Some organisations weight criteria, so some criteria carry more significance or importance in comparison with others. You may wish to consider the following criteria when applying QIA to clinical audit generated by local healthcare professionals (example of weighted average QIA provided to Management).

- **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

• **Interface project** — the level of involvement at the interface between two or more NHS establishments or organisations, particularly the primary care/secondary care interface.

It should be the responsibility of a delegated individual such as a clinical audit lead (or local clinical governance team) within the clinical area to assess potential projects on the above criteria, so that a decision is made as to whether or not a project should be carried out. This can ensure that good quality projects are being undertaken. Directorate/division/service audit projects could be identified from this process.

<table>
<thead>
<tr>
<th></th>
<th>No relevance (0)</th>
<th>Some relevance (1)</th>
<th>Almost met (2)</th>
<th>Met fully (3)</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>High frequency/volume</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(x2)</td>
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<tr>
<td>High cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(x2)</td>
</tr>
<tr>
<td>High risk</td>
<td></td>
<td></td>
<td></td>
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<td>(x2)</td>
</tr>
<tr>
<td>Potential for change</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(x2)</td>
</tr>
<tr>
<td>Existence of evidence-base</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(x2)</td>
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<tr>
<td>Direct involvement with patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(x2)</td>
</tr>
<tr>
<td>Wide variation in practice</td>
<td></td>
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<tr>
<td>Multidisciplinary project</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interface project</td>
<td></td>
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</tr>
<tr>
<td><strong>Total score =</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(x2)</td>
</tr>
</tbody>
</table>

If the criterion has no relevance, score = 0. If the criterion has some relevance, score = 1. If the criterion is met in parts, score = 2. If the criterion is fully met, score = 3. The scores can range between 0 and 42, with higher scores demonstrating higher priority.
Appendix 4

Online tools are available from the Quality Department website at: http://trustnet/departments/quality/clinicalaudit.html

Tools available are the Trust standards:

- Registration form (for submission to local area / division audit representative)
- Report form
- Action plan template

### CLINICAL AUDIT REPORT TEMPLATE

<table>
<thead>
<tr>
<th>DIVISION / SPECIALTY / NAME / JOB TITLE / DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AUDIT TITLE</strong> Including specific feature(s) of quality measured by the audit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BRIEF OVERVIEW / AIM</th>
<th>Audit summary, including aim(s) of the audit, audit measures (e.g. criteria, standards, guidelines) used to define quality of care. How will improvements in patient care be implemented?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>RESULTS</th>
<th>Analysis of data collected, stating clearly how measure(s) reflect quality of care</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CONCLUSIONS &amp; RECOMMENDATIONS</th>
<th>Discuss findings and identify changes required to improve patient care; state proposals e.g. training needs, action plans, posters, etc.</th>
</tr>
</thead>
</table>

**Action Plan**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Action required</th>
<th>Timescale</th>
<th>Person Responsible</th>
<th>Review &amp; Comments</th>
</tr>
</thead>
<tbody>
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Section 1 Organisational Policy

Current Version is held on the Intranet

Review date: March 2017

Issue 4

Page 22 of 25
**PROFORMA FOR RATIFICATION OF POLICIES AND GUIDELINES BY RATIFYING COMMITTEE**

<table>
<thead>
<tr>
<th>Policy/Guidelines Name:</th>
<th>Clinical Effectiveness &amp; Audit Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Person completing form:</td>
<td>Ann Spiropoulos</td>
</tr>
<tr>
<td>Date:</td>
<td>February 2014</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Author(s) (Principle contact)</th>
<th>Ann Spiropoulos</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of author or sponsor to attend ratifying committee when policy/guideline is discussed</td>
<td>Ann Spiropoulos</td>
</tr>
<tr>
<td>Date of final draft</td>
<td>February 2014</td>
</tr>
<tr>
<td>Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency?</td>
<td>Yes</td>
</tr>
<tr>
<td>By whom:</td>
<td>Members of the Clinical Effectiveness and National Audit Review Group (CENARG)</td>
</tr>
<tr>
<td>Is this a new or revised policy/guideline?</td>
<td>Revised</td>
</tr>
</tbody>
</table>

Describe the development process used to generate this policy/guideline. *Who was involved, which groups met, how often etc.?*


Who is the policy/guideline primarily for?

Clinical staff in all areas across the Trust

Is this policy/guideline relevant across the Trust or in limited areas?

Across the Trust

How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?

Via committee members noted above, clinical governance officers, eAspire

Describe the process by which adherence to this policy/guideline will be monitored. *(This needs to be explicit and documented for example audit, survey, questionnaire)*

Bimonthly reports to CENARG and annual report to Quality Governance Committee.

Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline?


This policy relates to implementation of best practice in clinical audit and follows the principles contained in the NICE book.

What (other) information sources have been used to produce this policy/guideline?

Trust Quality, Safety & Risk Management Strategy, Clinical Audit strategy documents from other NHS organizations.

Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation?

N/A

Other than the authors, which other groups or individuals have been given a draft for comment? *(e.g. staff, unions, human resources, finance dept., external stakeholders and service users)*
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members of CENARG, QGC including patient representative.</td>
<td></td>
</tr>
<tr>
<td>Which groups or individuals submitted written or verbal comments on</td>
<td>Members of CENARG, Deputy Director of Nursing and Quality, Internal</td>
</tr>
<tr>
<td>earlier drafts?</td>
<td>Auditor.</td>
</tr>
<tr>
<td>Who considered those comments and to what extent have they been</td>
<td>Ann Spiropoulos, document amended to incorporate the changes</td>
</tr>
<tr>
<td>incorporated into the final draft?</td>
<td></td>
</tr>
<tr>
<td>Have financial implications been considered?</td>
<td>N/A</td>
</tr>
</tbody>
</table>

N/A