Trust Policy		Worcestershire Acute Hospitals NHS Trust

Clinical Audit Policy

Department:	Clinical Effectiveness
Originator:	Jo Howden – Clinical Effectiveness Support Manager Elaine Chapman – Clinical Effectiveness Manager
Accountable Director:	Chief Medical Officer
Approved by:	Clinical Effectiveness Group
Date of approval:	16th April 2024
First Revision Due: This is the most current document and should be used until a revised version is in place	16th April 2027
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments:	All Clinical Departments
Target staff categories	Anyone engaged in the clinical audit process, including both clinical and non-clinical staff, student and trainees

Policy Overview:
This document outlines the provision of clinical audit for the Trust and details the aims, accountabilities, responsibilities, resources, systems and high level processes designed to establish a coordinated and effective approach to audit, ensuring that clinical audit drives quality improvement.

Key amendments to this document

Date	Amendment	Approved by:
February 2024	Major re-write of policy to allow for changes to the Clinical Effectiveness Team and internal processes. This policy replaces: • Clinical audit for improvement policy • Junior doctors clinical audit policy	

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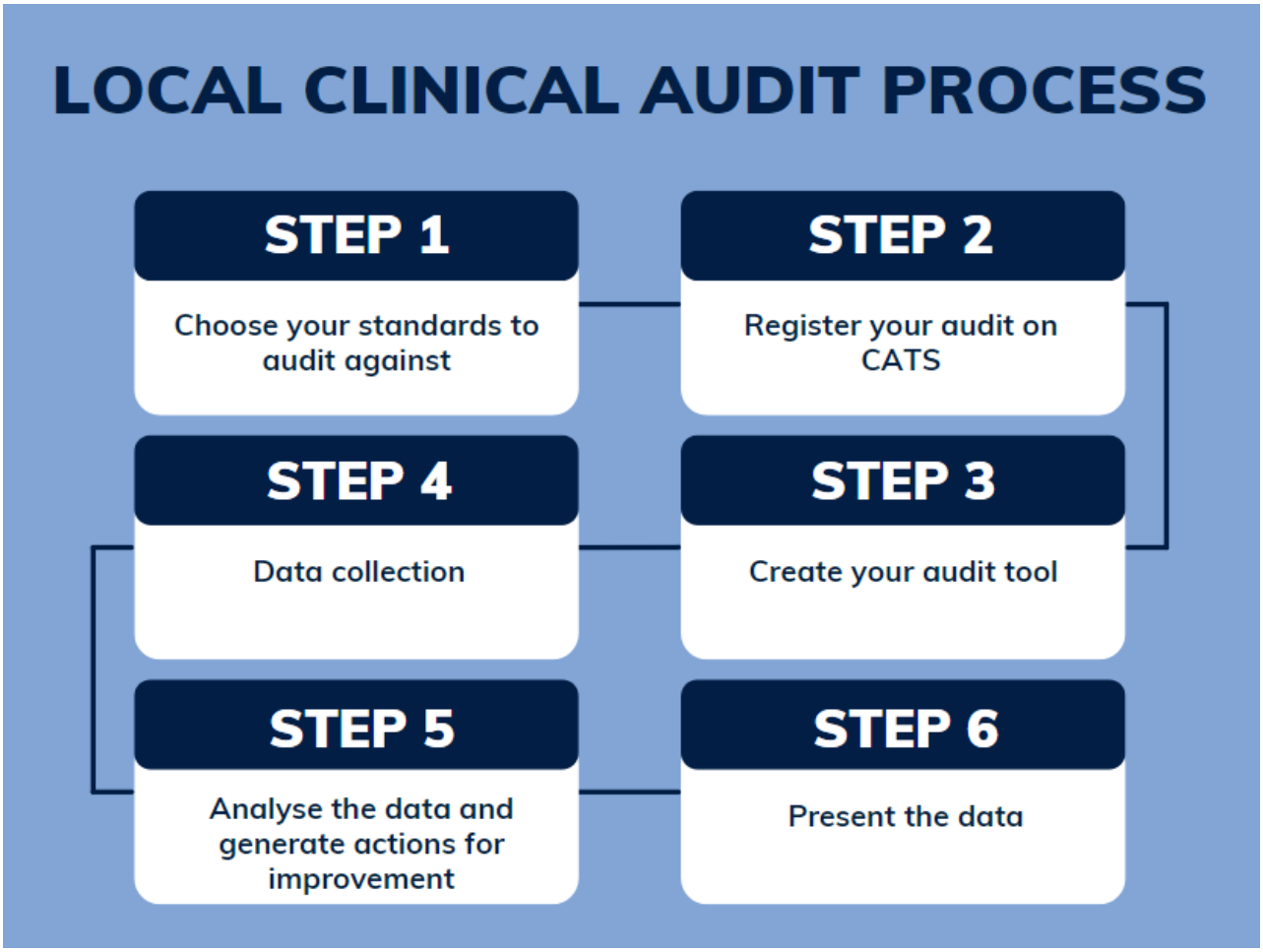
Appendices

Supporting Documents

Supporting Document 1	Equality Impact Assessment
Supporting Document 2	Financial Risk Assessment

QUICK REFERENCE GUIDE



1. Introduction

Clinical Audit is a quality improvement tool, and HQIP describe it as:

> *'Clinical Audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.'*
>
> *Healthcare Quality Improvement Partnership 'Best Practice in Clinical Audit', April 2020*

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

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

Participation in both national and local clinical audit is a statutory and contractual requirement for healthcare providers. The NHS standard contract forms the agreement between commissioners and providers of NHS-funded services who must;

- Participate in national clinical audits within the National Clinical Audit and Patient Outcomes Programme (NCAPOP) relevant to their services.
- Make national clinical audit data available to support publication of consultant-level activity and outcome statistics.
- Implement and/or respond to all relevant recommendations of any appropriate clinical audit.
- Implement an ongoing, proportionate programme of clinical audit of their services in accordance with good practice.
- Provide to the co-ordinating commissioner, on request, the findings of any audits carried out, in particular locally-agreed requirements such as Commissioning for Quality and Innovation (CQUIN) audits.

The regulatory framework, Care Quality Commission (CQC), requires registered healthcare providers to monitor the quality of their services. The CQC fundamental standards describe the care patients should expect, and provides prompts for providers to consider when aiming to meet requirements for governance and audit, set out in Regulation 17: Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

> *"To meet this regulation, providers must have effective governance, including assurance and audit systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The systems and processes must also assess, monitor and mitigate any risks relating to the health, safety and welfare of people using services and others. Providers must continually evaluate and seek to improve their governance and auditing practice."*

Providers must use the findings from clinical audits and other quality improvement initiatives, including those undertaken at a national level – such as national confidential enquiries – to ensure that action is taken to protect people who use our services. They must also ensure healthcare professionals are enabled to participate in clinical audit to satisfy the demands of their relevant professional bodies (for example, revalidation and professional development).

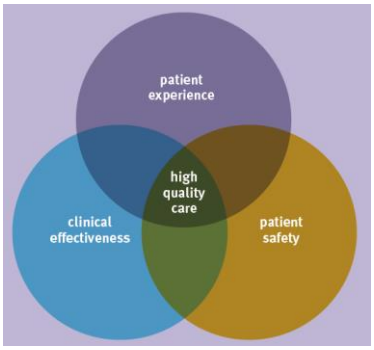
Under the Health Act 2009, the Trust is required to produce an annual Quality Account Report, which must include information on participation in national and local clinical audits, and the actions that have been taken as a consequence to improve the services provided

1.1 Purpose of this Policy

The purpose of this policy is to set out the rationale for clinical audit and provide a framework for such activity, including standards, guidance and procedures, as well as details of the support available from the Clinical Effectiveness Team, and the roles and responsibilities of all staff within the Trust.

1.2 Improvement and Assurance

Quality in the NHS was defined in 'High Quality Care for all: NHS next stage review', led by Lord Darzi, and enshrined in legislation through the Health and Social Care Act 2012. This set out the three dimensions, seen in Diagram 1, which must all be present to provide a high quality service.



- **Patient experience:** quality care is delivered for a positive experience, including being treated according to individual wants or needs, and with compassion, dignity and respect.
- **Clinical effectiveness:** quality care is delivered according to the best evidence regarding what is clinically effective in improving an individual's health outcomes.
- **Patient safety:** quality care is delivered to prevent all avoidable harm and risks to an individual's safety.

Quality improvement in healthcare is a process that seeks to enhance patient experience and individual health outcomes through measuring and improving the effectiveness and safety of clinical services.

Quality assurance in healthcare is the planned and systematic monitoring of activity to ensure that the requirements for safe, clinically effective services and positive patient experience are met. Quality assurance aims to provide confidence and certainty in the quality of services.

While **clinical audit** is fundamentally a quality improvement process that provides the opportunity for ongoing review and service development, it also plays an important role in providing assurance on the quality of services.

It is the responsibility of clinicians, who provide care to patients, to undertake clinical audit. The Trust is committed to supporting all staff who carry out clinical audit by providing advice and assistance from the appropriately trained and experienced Clinical Effectiveness Team. Appropriate training can also be made available to all staff who carry out clinical audit projects.

The Trust is committed to ensuring;

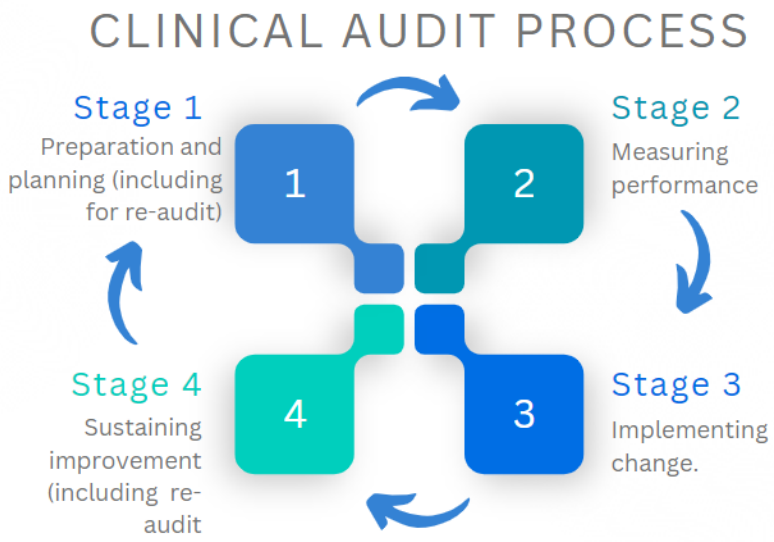
- Participation in all national clinical audits and national confidential enquiries.
- All clinical audit activity within the Trust, or conducted in partnership with external bodies, is registered via the appropriate channels
- The Clinical Audit Forward Plan supports the Trust's objectives and includes any clinical audits necessary to meet the requirements of regulators and commissioners.
- Regular reviews of the Clinical Audit Forward Plan, individual clinical audit projects, as well as the results of national clinical audits and national confidential enquiries are maintained to;
  - Help facilitate effective clinical audit activity through robust governance systems
  - Demonstrate compliance with requirements of regulators and commissioners.

For the processes to be followed for National Confidential Enquiries into Patient Outcomes and Death (NCEPOD), please refer to the NCEPOD Policy on the key documents intranet page.

1.3 Definition of Clinical Audit

Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality care, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes. (*Principles of best practice in clinical audit, HQIP, 2020)*

The Trust is committed to using the clinical audit process to drive improvement. The clinical audit model below outlines the clinical audit cycle;



NOTE:
Between the stages of **'measuring performance'** and **'implementing change'** the following processes must be undertaken:

- **Checking** on clinical audit findings
- **Reporting compliance** properly
- **Analysing variation** in clinical practice
- **Analysing shortcomings** in care to find their **root causes**
- **Planning and taking** the **right actions.**

Stage 1 – Preparation and Planning: to agree required standards and clinical audit methodology
Stage 2 – Measuring Performance: data collection in order to evaluate performance against required standards
Stage 3 – Implementing Change: using action planning where shortfalls are identified
Stage 4 – Sustaining Improvement: through monitoring and service development, with repeated clinical audit cycles as required

Although there are similarities, the clinical audit cycle should not be confused with the Plan, Do, Study Act cycle (PDSA Cycle), which is a separate quality improvement tool used to drive and increase compliance with standard/s against which there is an identified shortfall, or to investigate the impact of changes to practice within a defined timeframe, and is a useful tool whilst undertaking your audit and testing change.

2. Scope of this document

2.1 Target audience

This policy applies to anyone engaged in the clinical audit process within the Trust, including:

- All staff, both clinical and non-clinical, and those on short-term or honorary contracts
- Students and trainees in any discipline
- Patients, carers, volunteers and members of the public who the Trust engages in clinical audit activities

This policy also applies when clinical audit is undertaken jointly across organisational boundaries.

2.2 Multidisciplinary and multi-professional audit, and partnership working with other organisations.

The Trust encourages clinical audit to be undertaken jointly across professional and organisational boundaries. Partnership working with other local and regional organisations will be encouraged where improvements to the patient journey may be identified through shared clinical audit activity.

The Trust also supports collaboration on multi-professional clinical audits of interest to other parts of the local health and care economy, both within and outside the NHS, e.g. primary/secondary care, local authorities, independent health and social care providers etc.

3. Definitions

CATS – Clinical Audit Tracking System

This is the system that provides;

- On-line registration for clinical audit
- Transparency for the Trust of all clinical audit activity that has been registered
- Monitoring action plans
- Recording changes made as a result of audit
- Reporting

NCAM – National Clinical Audit Module

This is the sub-system of CATS that provides;

- On-line registration for clinical National Audits
- Transparency for the Trust of all national clinical audit activity
- Monitoring action plans
- Recording changes made as a result of audit
- Reporting

HQIP – Healthcare Quality Improvement Partnership

HQIP is the UK's largest national clinical audit commissioner and was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality improvement. They are an independent organisation led by the Academy of Medical Royal Colleges and the Royal College of Nursing.

HQIP aims to improve health outcomes by enabling those who commission, deliver and receive healthcare to measure and improve our healthcare services.

HQIP – Healthcare Quality Improvement Partnership

Responsibility and Duties

All staff

All staff employed by the Trust have a responsibility for the continual improvement of the quality of the service they provide and all clinical staff are individually accountable for ensuring their own practice is audited in accordance with their professional codes of conduct and in line with the standards set out within this policy.

Chief Executive

The Chief Executive is responsible for the statutory duty of quality and takes overall responsibility for this policy, for effective prioritisation to participate in national clinical audit and for decisions about local clinical audit.

Chief Medical Officer

The Chief Medical Officer is the executive lead for clinical audit and their responsibilities in respect of clinical audit are:

- To ensure that the Trust's Clinical Audit Policy and annual programme of work (Clinical Audit Forward Plan) are aligned to the Board's strategic interests and concerns.
- To ensure that clinical audit is used appropriately to support the Board Assurance Framework.
- To ensure that the Clinical Audit Policy is implemented across all clinical areas.
- To ensure that any serious concerns regarding the Trust's policy and practice in clinical audit, or regarding the results and outcomes of national and local audits, are brought to the attention of the Board.

Clinical Effectiveness Manager

The Clinical Effectiveness Manager is responsible for developing and implementing corporate systems and processes to support clinical audit activities. The Clinical Effectiveness Manager ensures that eligibility to participate in national audits is assessed, and that there is a prioritised local clinical audit forward plan, supported by the Chief Medical Officer. They ensure that information is compiled for the clinical audit element of the Quality Accounts.

Clinical Effectiveness Team

The roles of the Clinical Effectiveness Team are to:

- Facilitate and support the creation and completion of the Trusts Annual Clinical Audit Forward Plan with the Specialty Audit Leads.
- Manage and oversee the process for the Trust's participation in national clinical audits.
- Assist in the further development and implementation of clinical audit within the Trust.
- Develop and implement clinical audit and quality improvement processes, methods and techniques.
- Provide expert advice, support and practical help to support projects
- Provide clinical audit training to identified staff
- Maintain the trust's system for clinical audit registration
- Support and facilitate cross-boundary audits
- Develop clinical audit tools and data capture systems
- Support clinicians to analyse data, report writing and creating presentations
- Review and facilitate clinical audit activity by quality checking registrations, reports and action plans.
- Promote quality improvement methodology throughout the audit process.

Clinical Directors

Clinical Directors ensure that a senior clinician within each specialty within their directorate is nominated as the Specialty Audit Lead for clinical audit. Where no Specialty Audit Lead has been nominated, this role will be the responsibility of the Clinical Director. Clinical Directors:

- Ensure that the Clinical Audit Policy is implemented throughout their directorate.
- Ensure that all clinical audit activity is registered on the Clinical Audit system and complied with nationally accepted best practice standards.

- Ensures that their directorate participates in all national clinical audits and national confidential enquiries that are relevant to the services provided.
- Ensures that the clinical audit programme for the directorate meets all clinical, statutory, regulatory, commissioning and Trust requirements.

Specialty Clinical Audit Leads

The key responsibilities of a Specialty Audits lead for each specialty are to:

- Act as a Champion for Clinical Audit, explaining and promoting the importance of clinical audit and the Trust's policies relating to clinical audit to colleagues, including doctors and other healthcare professionals in training.
- Ensure the Clinical Audit Policy is adhered to within their specialty.
- Ensures that their specialty participates in all national clinical audits and national confidential enquiries that are relevant to the services provided.
- Approves audit registration forms, in compliance with this policy.
- Work in liaison with all staff within their specialty to lead the development of the Clinical Audit Forward Plan, ensuring that it meets all clinical, statutory, regulatory and commissioning requirements.
- Ensure that people working in the service carry out clinical audits to drive improvement.
- Monitor and manage progress on national and local clinical audits.
- Facilitate both the analysis of areas that require improvement as indicated by clinical audits and the resulting actions aimed at improving the quality or safety of care.
- Support colleagues to carry out clinical audit, including junior doctors, using a team approach.
- Provide effective lines of communication relating to clinical audit within the specialty and division and to the Clinical Effectiveness Team.
- Ensure that the work being carried out on clinical audits is shared within the clinical service, including to management and governance-related groups
- Ensure that learning is shared from clinical audit, for example in specialty audit meetings, Grand Rounds, training sessions, governance meetings etc.
- Assigning or approving clinical audit for junior doctors, whether for a group or individuals.
- Arranging for peer review of a clinical audit/registration submitted by junior doctors and providing feedback on such proposals.
- Ensuring that junior doctors have access to appropriate and effective training on how to carry out a clinical audit, either by providing such training or by referring junior doctors to training available in the Trust or elsewhere.
- Providing advice and support on the design and execution of clinical audit as needed.
- Monitoring completion of the specific clinical audit that have been approved and prompting junior doctors to meet the agreed timetable for the work, as needed.
- Ensuring that junior doctors understand requirements relating to ethics and data protection in relation to clinical audit and quality improvement

National Clinical Audit Leads

The key responsibilities of National Clinical Audit Leads are to:

- Ensure that the Trust is able to participate in the national clinical audit they lead on, and to escalate any obstacles to participation to the Specialty Clinical Audit Lead, with further escalation to the divisional governance meetings where these obstacles cannot be overcome without support.
- Ensure that all data collection is completed by the deadline and that all information governance instructions are complied with, including the national data opt-out requirements.
- Receive all national clinical audit reports and develop improvement plans to address any recommendations, using quality improvement methodology.
- To lead on the delivery of the improvement plan.
- Complete an initial Baseline Summary on NCAM and set an aim statement for what needs to be improved based on the areas of low compliance and present this to the relevant specialty/directorate/governance meeting. Continue to provide regular updates on the progress of the aim that was set to the Clinical Effectiveness Team via NCAM and to present the update to the relevant specialty/directorate/governance meeting.

Junior doctors

Individual junior doctors are responsible for meeting their requirements for involvement in clinical audit and QI, consistent with their training requirements, including for the following:

- Carrying out a clinical audit consistent with the understanding of the clinical audit processes as described in this policy
- Completing and submitting the Trust's clinical audit registration form for the project.
- Completing and submitting the Trust's clinical audit/presentation for the project, using the Trust's template.
- Taking part in clinical governance and audit meetings.

Divisional Management Teams

Divisional Management Team responsibilities are to:

- Ensure that the Clinical Audit Policy is implemented within their division.
- Nominate a senior clinician within each specialty as the Specialty Audit Lead.
- Support each specialty to produce an annual prioritised audit
- Develop and implement effective mechanisms for assuring the quality and appropriateness of local and national clinical audit activity.

Divisional Governance Teams

Divisional Governance Teams support the Specialty Leads and Divisional Management Teams to fulfil their responsibilities and ensure that clinical audit activities follow the governance requirements of this policy in addition to any divisional requirements.

4. Policy

5.1 Annual Clinical Audit Forward Plan

The Clinical Audit Forward Plan is broken down into 2 sections:

Tier 1 – External 'Must Do's'

- NCAPOP and other national clinical audits relevant to the services provided, and/or where participation must be reported in Quality Accounts (Quality Accounts are a list of National Audits that are published by NHS England where there is a requirement for all trusts to participate in and this information is reported out to external regulators)
- Audits demonstrating compliance with regulatory requirements, e.g. national guidance such as that generated by the Clinical Outcomes Review Programme (CORP – covering National Confidential Enquiries and Inquiries)

Tier 1 - Organisational Priorities

Organisational priority audits will be set at a corporate/trustwide level.

Tier 2 – Internal Priorities

Local clinical interest audits agreed by the directorate/division/service as a priority. These could include:

- Clinical risk issues
- Audits undertaken in response to serious untoward incidents/adverse incidents
- Complaints
- NICE Guidance
- Local trust policies and guidelines

Setting Divisional Priorities

Each division should identify a ***small number*** of manageable audits on the divisional plan that address any areas within Tier 2 – Internal Priorities.

It is not mandatory for every specialty to have audits included, if there are no areas of identified concern at this time. Audits can be registered at any time as the need arises, outside of the Audit Forward Plan.

5.2 Local clinical audit

Clinical audit involves measuring clinical practice against predetermined standards of best practice.

For instance:

- Clinical guidelines from professional bodies (e.g. DH, Royal Colleges).
- NICE
- Trust Policies/pathways
- Incidents
- Risk

Audit standards should be evaluated and approved by the Specialty Audit Lead prior to the commencement of the project. Where no standards exist, the project will only be registered if, as part of the project, some clinical standards will be developed.

5.2.1 Data collection

5.2.2 Analysis

5.2.3 Reporting/Presenting

All clinical audit projects must be written up in a report or presentation, ensuring that compliance against the standards is documented and an action plan is produced. Templates are available to support this from the Clinical Effectiveness Team

Completed clinical audit projects should be presented at specialty audit or governance meetings.

The project lead/specialty audit lead should ensure that there are ways of feeding back the findings from the audit and that they are disseminated to all key stakeholders. This includes the staff and services who took part in the audit, related or similar services in other divisions, and service users/carers where appropriate. All approved audit reports will be available on the Clinical Audit Tracking System (CATS).

Shared learning from clinical audit is an important part of the process. It offers the opportunity to identify common themes across other work streams such as incidents, risks, complaints and facilitates organisational learning.

5.2.4 Action Plans

The main purpose of clinical audit is to deliver improvements in clinical practice and patient care.

Where the initial results of a clinical audit indicate areas for improvement, actions must be developed in conjunction with stakeholders and implemented

There must be identified lead for each action. The recommendations and actions must have the agreement of all or the majority of stakeholders involved in the clinical audit process, including managers who may have to commit resources to the changes.

The supervisor of the audit must ensure the recommendations and action plan are closely monitored and progress updated to the clinical audit system on a regular basis. Divisions will establish arrangements for monitoring that action plans have been satisfactorily completed, and gather assurance that improvement has resulted.

Not all clinical audits will require an action plan. E.g. where an audit shows that standards are consistently and repeatedly being met, and practice is effective. For such audits there should be an explicit statement within the report that no further action is required, along with the reason for this.

Actions should be SMART:

Specific
Measurable
Achievable
Relevant
Time bound

5.3 National clinical audit

The National Clinical Audit Patient Outcomes Programme (NCAPOP) is managed by Healthcare Quality Improvement partnership (HQIP) and it is a current statutory, mandatory and contractual requirement for the Trust to participate. Participation will be monitored by the Commissioners as part of the contract. NCAPOP relates to some of the most frequently occurring conditions to assess a national picture of standards of care the patients receive. Cardiology, Respiratory, and Surgery are some of the key areas.

The national audit teams provide local Trusts with individual benchmarked reports on their compliance and performance. Recommendations are also provided on how to ensure standards of care in the Trust are improved. The requirement is that an initial Baseline Summary report, to include an aim statement for improvement, and action plan is formulated to implement the recommendations as part of the quality improvement process.

National Audit Process
The Clinical Audit Team will horizon scan for any new national clinical audits for which the Trust is eligible to participate.

Where a new national audit is to commence the Clinical Effectiveness Team will send an Assessment for National Clinical Audit form to the Clinical Director for the relevant specialty. The Clinical Director will complete the assessment form outlining the eligibility of the audit and any resource implications relating to participation.

The Clinical Director will identify a named lead for the national audit.

For multi-specialty audits the Assessment for National Clinical Audit form needs to consider the impact across all areas. The baseline assessment will be returned to the Clinical Effectiveness Team.

The named clinical lead for the national audit will register to participate in the national audit with the relevant National Team.

The Clinical Effectiveness Team monitor the Trust's participation ~~and non-participation~~ in Mandatory National Audits for which the Trust is eligible to participate. Non-participation should be registered as a risk by the Divisional Medical Director and an action plan developed to achieve participation. Non-participation should be regularly discussed in Divisional Governance Meetings and reported to Clinical Effectiveness Group by the relevant Division so that steps to overcome obstacles to participation can be explored.

The Clinical Effectiveness Team will monitor participation in national audits on an ongoing basis, and seek evidence that reports have been reviewed and an action plans completed and progressed.

Consistent with the approach for local clinical audit, it is recommended that quality improvement methodology is used to determine the root cause of any shortfalls in performance, and to identify and test changes.

Updates on national audits will be included within the Clinical Effectiveness Teams Quarterly Clinical Effectiveness report to the Clinical Effectiveness Group and the annual Quality Accounts.

A Clinical Effectiveness Annual Report will be produced each year. It will provide an overview of clinical audit activity for the year and plans for the forthcoming year. It will be approved by the Clinical Effectiveness Group.

Data Opt Out
The NHS Act 2006 Section 251 makes provision for the use of patient identifiable data in the interests of improving patient care and in the public interest. The Trust's local arrangements for adhering to the National Data Opt Out requirements, as outlined by Information Governance, must be adhered to.

The Clinical Lead is responsible for ensuring that patient identifiable data is sent to the Information Team to be ran through a national system called MESH to see which patients have opted out. Once this has been done, the Clinical lead can then submit the data to the national audit.

For the processes on how to comply with the Opt Out Process in our Trust, refer to the National Data Opt Out Process document on the key documents intranet page.

5.4 Quality Account

The Quality Account is a list of National Clinical Audits, Clinical Outcome Review programmes and other national quality improvement programmes which NHS England produce for each financial year. Some of these national audits are mandatory as they fall under the NCAPOP work stream and others are audits that NHS England advises Trusts to prioritise participation and inclusion in their Quality Account report at the end of the financial year.

The audits and outcome review programmes that sit on the Quality Account, which the Trust is eligible to participate in, are also included in the Trusts Clinical Audit Forward Plan

5.5 Junior doctors

Foundation Doctors and Registrars are responsible for ensuring that they understand the specific expectations of the relevant Royal Colleges in relation to their participation in clinical audit and quality improvement projects.

Assigning clinical audits
The Specialty Audit Lead should assume responsibility for designing a programme for involving Foundation Programme doctors in clinical audit in the specialty. The Specialty Audit Lead should also ensure that registrars in the specialty have selected or are assigned important clinical audits to carry out, and that the audits are included in the specialty's annual audit plan

Ways of involving Foundation Doctors in clinical audit
The following approaches are acceptable ways of involving Foundation doctors in clinical audit/quality improvement in the Trust.

Sharing and handing over clinical audits among Foundation doctors
A group of F1 or F2 doctors or individual F1 or F2 doctors can be assigned to carry out a clinical audit. The group, team or individual would be involved in designing or refining a clinical audit in the clinical service; collecting data for the audit; collating and interpreting the findings; identifying the root causes of any problems in practice revealed by the clinical audit; agreeing the measures for improvement; generating some change ideas; testing the change ideas on a small scale to see if practice is improved; repeat changes and testing, using further data collection, until practice has improved; implementing successful, sustainable changes; scaling up and spreading the changes where appropriate; further checking for sustained changes as necessary.

Examples of sharing work on a clinical audit can include any of the following arrangements:

- Two or more F1 or F2 doctors (maybe the 'triplet' Foundation doctors' groups) can work on the same audit in the same clinical service by sharing data collection for different wards, clinics, theatres, special care units or sites.
- Two or more F1 or F2 doctors can work on the same audit in different clinical specialties within a directorate/ division, for example, different surgical specialties.
- A group of F1 or F2 doctors can work on a Trust clinical audit, such as on consent.

Foundation doctors may hand over the work completed so far on a clinical audit to the doctors coming into the clinical service. For example, an F1 doctor in a clinical service may design and carry out a clinical audit through data collection and reporting, indicating the need for improvement. Then, an F1 doctor coming into the rotation can work through the change process and repeat data collection for the clinical audit.

All Foundation doctors participating in the clinical audit will be acknowledged by the Trust as meeting their training requirements related to clinical audit as long as evidence of each doctor's contribution to the audit is clearly documented in the clinical audit report submitted to the Trust.

Ways of involving registrars in clinical audit and quality improvement
Although registrars are expected to carry out a clinical audit independently, they can work on the same or a related clinical audit subject, working together or in parallel. For example, one registrar could carry out a clinical audit on the appropriateness of clinical decision-making related to an area of practice and another could carry out an audit on the effectiveness of care provided related to the same area of practice.

Recognition of clinical audit for junior doctors
Junior doctors will be eligible to receive a formal certificate of their participation in clinical audit if they meet the Trust's requirements for participation. The certificate is issued following registration of the audit project on the Clinical Audit Tracking System (CATS) and submission of the report or presentation to the Clinical Effectiveness Department.

5.6 Clinical Audit Tracking System

All clinical audit activity, whether included on the Trusts Clinical Audit Forward Plan or being completed outside of this, must be registered on the Clinical Audit Tracking System (CATS), irrespective of the level of support required of the Clinical Effectiveness Team.

The system includes an electronic audit registration form that must be completed by the project lead and will then go to the Specialty Audit Lead for approval.

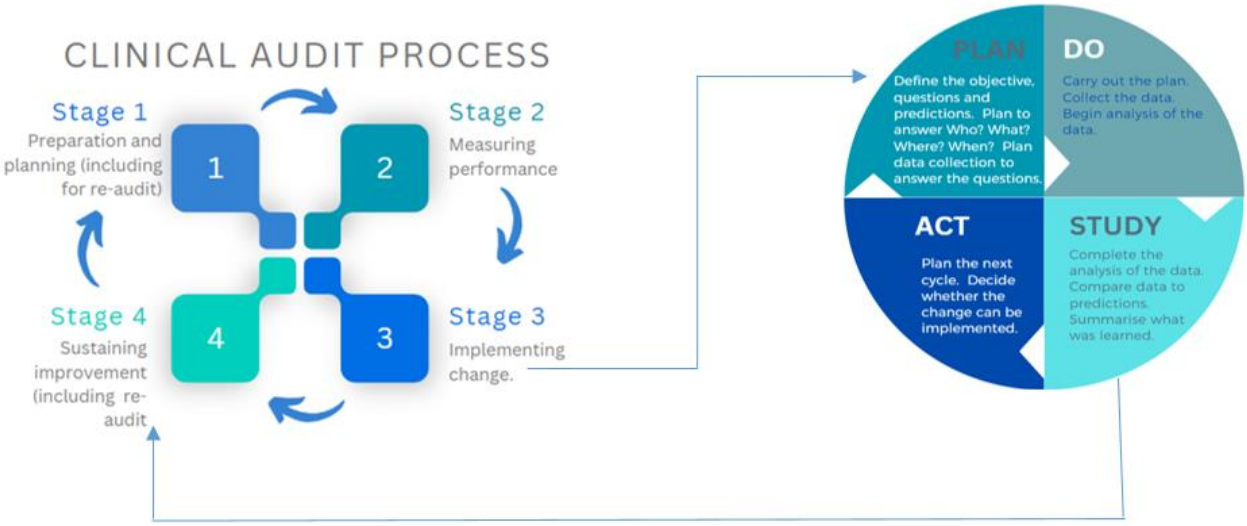
Data provided on this form will be used to compile a register of all clinical audit activity undertaken throughout the trust.

Audit projects should be carried out under the leadership of a named clinician, and it is recommended that a team approach is adopted to ensure continuity in projects, particularly to safeguard against projects failing when junior doctors move on to new areas.

5.7 PDSA Cycles

The Trust encourages the use of PDSA cycles when undertaking a clinical audit, and it is recommended that at least 2 cycles should be completed for any given clinical audit.

By undertaking PDSA cycles, this ensures that the small changes, 'mini actions', that have been put into place are the correct ones and are sustainable. These changes will then be checked, by way of a subsequent PDSA cycle where further data can be collected and findings analysed. If compliance has improved to the desired level, then the audit can be completed and a re-audit undertaken at least 12 months in the future. If compliance still hasn't improved enough, the process should be repeated with a 3rd, 4th PDSA cycle and further small changes can be implemented



5.8 Re-audit

The term re-audit implies that repeating a data collection is another audit and not the completion of the original audit. A Quality Improvement approach to clinical audit makes it clear that the subsequent data collection cycles are part of the original audit and that repeating data collection cycles (PDSA) is essential to complete a singular audit.

Only when you have reached your desired level of compliance in your clinical audit, and the actions have had time to fully embed, should you consider undertaking a re-audit at least 12 months down the line, as this will demonstrate if the changes made were sustainable longer term.

5.9 Training

The Trust will make available suitable training and awareness programmes to all relevant staff regarding the systems and arrangements for participating in clinical audit.

The following training modules are available on the trust intranet

- Clinical Audit Overview
- Clinical audit – Assurance
- Requesting Patient Data
- Designing an Audit Tool
- Creating a Sample Size

1-2-1 training and support is available from the Clinical Effectiveness Team.

6 Implementation

6.7 Plan for implementation

In order to implement and evaluate the Clinical Audit Policy the Clinical Effectiveness Team will:

- Ensure that the policy is effectively communicated across the Trust. This will be achieved through the dissemination process described below.
- Continually monitor the implementation of the policy.
- Review and revise the policy within specified timescales.
- Facilitate a continuous cycle of clinical audit, promoting quality improvement methodology.
- Make available training in clinical audit to staff.

6.8 Dissemination

6.9 Training and awareness

This policy sets out how the Trust will ensure that all clinicians and other relevant staff conducting and/or managing clinical audits can obtain the knowledge and skills to facilitate completion of clinical audit projects. Clinical audit education and training are key to the delivery of this policy, in order to promote activity led by healthcare professionals.

The Trust will make available suitable training and awareness programmes to all relevant staff regarding the systems and arrangements for participating in clinical audit.

- Clinical audit training sessions are available to any member of staff at various levels.
- 1:1 support sessions are available from the Clinical Effectiveness Team.
- Educational resources on clinical audit processes are available through the Healthcare Quality Improvement Partnership (HQIP) website. www.hqip.org.uk
- A range of Quality Improvement guides and tools are available from NHS Improvement https://improvement.nhs.uk/

Clinical Effectiveness Staff

The Trust will employ a team of suitably skilled Clinical Effectiveness Facilitators to support the Trusts clinical audit activity. The Trust will ensure that staff have access to further relevant training in order to maintain and develop their knowledge and skills.

Clinical Effectiveness staff will be expected to participate in professional training and development activities relevant to their role.

7 Monitoring and compliance

[This section should identify how the Trusts plan to monitor compliance with and the effectiveness of this Policy. It should include auditable standards and/or key performance indicators (KPIs) and details on the methods for monitoring compliance]

The NHSLA requirements are –

Organisations should measure, monitor and evaluate compliance with the minimum requirements within the NHSLA Risk Management Standards. This should include the use of audits and data related to the minimum requirements. The organisation should define the frequency and detail of the measurement, monitoring and evaluation processes.

Monitoring demonstrates whether or not the process for managing risk, as described in the approved documentation, is working across the entire organisation. Where failings have been identified, action plans must have been drawn up and changes made to reduce the risks. Monitoring is normally proactive - designed to highlight issues before an incident occurs - and should consider both positive and negative aspects of a process.

The table below should help to detail the 'Who, What, Where and How' for the monitoring of this Policy.

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	The Trust will have in place each year a Clinical Audit Forward Plan which specifies the audit priorities for the forthcoming year in the clinical divisions.	Clinical Effectiveness Team to liaise with divisions and specialities and support the development of each specialty's Forward Plan.	Annual	Clinical Effectiveness Group	Clinical Effectiveness Group	Annual
	Local and National Audit is completed each year, and is carried out in accordance with Trust Policy, including completion of actions identified within action plans and identification of improvements made as a result of the audit.	All audit activity is monitored at directorate and divisional level.	At least bi-monthly	Clinical Effectiveness Group	Clinical Effectiveness Group	Quarterly
	The Trust participates in all National Audits it is eligible to participate in.	The Clinical Effectiveness Team works with National Audit Leads to ensure action is taken to address any obstacles to participation.	Monthly, as required	Clinical Effectiveness Team	Clinical Effectiveness Group	Quarterly

8 Policy Review

The policy will be reviewed three years after approval or sooner in the event of any significant changes in the Trust structure or processes that require amendment

9 References

References: Code:

Clinical Audit How to Guide for Project Leads	
National Data Opt Out Process	

10 Background

10.7 Equality requirements

This Policy has identified a neutral impact to staff, public, patients, carers etc. and has not identified any potential negative impacts. See supporting document 1 for full details

10.8 Financial risk assessment

The implementation of this policy does not require any additional capital resources, additional revenue, manpower and does not release any manpower costs. Additionally, there are no additional staff training costs associated with implementing this policy. See supporting document 2 for full details.

10.9 Consultation

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Chief Medical Officer
Clinical Effectiveness Manager
Clinical Effectiveness Support Manager

This key document has been circulated to the chair(s) of the following committees/groups for comments;

Committee
Deputy Chief Medical Officer
Divisional Medical Directors/ Heads of Governance
Director of Medical Education
Speciality & National Audit Leads
Divisional Governance Leads
Clinical Effectiveness Team

10.10 Approval Process

This Policy is approved by the Clinical Effectiveness group

Supporting Document 1 – Equality Impact Assessment form

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	X	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Chief Medical Officer**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Jo Howden	**Clinical Effectiveness Support Manager**	wah-tr.ClinicalAudit@nhs.net
Date assessment completed			

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Clinical Audit policy

What is the aim, purpose and/or intended outcomes of this Activity?	Clinical audit is a quality improvement tool and its aim is to provide assurance that clinical standards are met and to continuously improve the outcomes for patients				
Who will be affected by the development & implementation of this activity?	✓ ✓ ❑ ❑	Service User Patient Carers Visitors	✓ ❑ ❑ ❑	Staff Communities Other _____	
Is this:	✓ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?				
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	The Policy follows best practice guidance as determined by the Healthcare Quality Improvement Partnership (April 2020).				
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Consultation described in Section 10.9 of the policy.				
Summary of relevant findings					

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		✓		
Disability		✓		
Gender Reassignment		✓		
Marriage & Civil Partnerships		✓		
Pregnancy & Maternity		✓		
Race including Traveling Communities		✓		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Religion & Belief		✓		
Sex		✓		
Sexual Orientation		✓		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		✓		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		✓		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	N/A	N/A	N/A	N/A
How will you monitor these actions?	N/A			
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	J. Howden
Date signed	
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document: Clinical Audit Policy	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval