## UHL Clinical Audit Policy

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<tr>
<th><strong>Approved By</strong></th>
<th>Policy &amp; Guideline Committee</th>
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Clinical Audit Policy

NB: Paper copies of this document may not be most recent version. The definitive version is held on INsite Documents
Review dates and details of Changes made during the review

This policy has been fully reviewed and signed off by Clinical Audit Committee March 2016. The main changes to the policy have been policy statements have been added along with clarity around the role of audit supervisor.

Key Words
Clinical Audit, Quality Improvement, Service Evaluation
1 Introduction

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trust’s Policy and Procedures for Clinical Audit. UHL is committed to delivering effective Clinical Audit in all the clinical services it provides. The Trust sees clinical audit as an essential part of its arrangements for monitoring and maintaining high quality patient-centred services.

1.2 When carried out in accordance with best practice standards, clinical audit is a quality improvement process that seeks to improve the quality of care and patient outcomes. Clinical audit also identifies and minimises risk, waste and inefficiencies and provides assurance of compliance with clinical standards.

2 Policy Aims

2.1 This policy outlines the roles, responsibilities and arrangements for Clinical Audit within the Trust. It provides standards and guidance for all staff participating in clinical audit activities. It includes the Trust’s procedures and expectations:

- for registering and approving clinical audit project plans/summaries;
- for developing and designing clinical audit projects;
- for reviewing and monitoring the impact of the clinical audit programme;
- and sets out the support that is available from the Clinical Audit Team.

2.2 All clinical audit activity (and other quality improvement projects) undertaken in the Trust must comply with the requirements of this policy.

2.3 This policy and related policy statements and procedure documents are underpinned by the Clinical Audit Strategy and strategic objectives (link) which is agreed on a 3 year basis (reviewed annually).

3 Policy Scope

3.1 The target audience

This policy applies to anyone engaged in the clinical audit process under the auspices of the Trust. This includes:

- all staff, both clinical and non-clinical, including staff on short-term or honorary contracts;
- external auditors and regulators;
- students and trainees in any discipline;
- patients, carers, volunteers and members of the public.

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

4 Definitions

Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes. (HQIP ‘New Principles for Best Practice in Clinical Audit’. Radcliffe Publishing, 2011)
5 Roles and Responsibilities

5.1 The roles and responsibilities for all staff to enable the effective management and impact of clinical audit are detailed below:

5.2 The Chief Executive is responsible for the statutory duty of quality and takes overall responsibility for this policy

5.3 The Board lead for Clinical Audit is the Chief Nurse (and she delegates this to the Director of Clinical Quality).

5.4 The Director of Clinical Quality has responsibilities in respect of Clinical Audit are:
   a. To ensure that the Trust clinical audit strategy and annual programme of work are allied to the Boards strategic interests and concerns
   b. To ensure that clinical audit is used appropriately to support the Board Assurance Framework
   c. To ensure this policy is implemented across all clinical areas
   d. To ensure that any serious concerns regarding the Trust’s policy and practice in clinical audit, or regarding the results and outcomes of clinical audits, are brought to the attention of the Board”

5.5 The Clinical Audit Manager is the operational lead for Clinical Audit and manages both the clinical audit programme and clinical audit team.

5.6 The Clinical Audit Committee is the committee tasked with overseeing the Trust’s Clinical Audit activities (link to Terms of reference). Any concerns raised by this committee are escalated to CMG Quality Boards and / or direct to the Executive Quality Board (EQB). The Clinical Audit Governance and Escalation structure for the Trust is detailed in appendix 2.

5.7 Clinical Audit team are responsible for providing expertise, training & support for Clinical Audit within the Trust. The team also have a responsibility with regards to ethical and information governance oversight of Clinical Audit and will refer any concerns to the Research and Development Department or Head of Privacy accordingly.

5.8 CMG Management Teams are responsible for ensuring that service development and delivery is underpinned by Clinical Audit and forms part of Continuing Professional Development / Service Reviews. All Clinical Directors must ensure that a senior clinician within each speciality is nominated as the Speciality Lead for Clinical Audit and provide suitable time in their job plan to undertake the role.

5.9 Each CMG has its own structure for Clinical Audit, including designated clinical leads for Clinical Audit, and department audit meetings where registers of attendance are kept (see appendix 1 for link to list of audit leads and intranet page showing CMG Clinical Audit structures)

5.10 Clinical Audit Leads (Speciality) are responsible for the leadership of a Speciality annual clinical audit programme and the development of clinical audit within the Specialty. The responsibilities of the speciality Leads for Clinical Audit are detailed in the audit leads job description (link).

5.11 Audit Supervisors of each audit are required to:
   - they are suitably conversant with the principles and practice of clinical audit
   - the project is planned and registered before starting data collection
   - that all ‘interested parties’ have been consulted before the proposed project commences (data should not be gathered about clinicians’ practice for clinical audit purposes without their prior knowledge)
• that due consideration has been given to the involvement of patients
• that the proposed audit has clearly defined aims/objectives relating to achievable improvements in quality, and uses (or sets) explicit standards of care.
• that no healthcare professional or patient can be identified directly or indirectly from a report without their explicit approval
• Present audit findings in appropriate meetings in their own speciality/CMG and beyond, according to the nature of the subject
• that the clinical audit summary form is completed in a timely manner and set to speciality audit lead / Head of Service for sign-off
• that any external publication of audit results receives the prior approval of the speciality audit lead / Head of Service.

5.12 All staff employed by the Trust has a responsibility for the quality of the service which they provide, and all clinically qualified staff are individually accountable for ensuring they audit their own practice in accordance with their professional codes of conduct and in line with the standards set out within this document.

6 Policy Statements
This policy is supported by the following statements found in the associated documents as detailed below, which must be used in conjunction with this policy:

Key Statement 1
All clinical audit projects (and other quality improvement projects) must be planned and formally registered using the clinical audit planner (link)

Key Statement 2
The Trust encourages clinical audit undertaken jointly across professions and across organisational boundaries. Partnership working with other local, regional and national organisations will be encouraged where improvements to the patient journey may be identified through shared clinical audit activity.

Key Statement 3
The Trust promotes a commitment to the principle of involving patients/carers in the clinical audit process either indirectly through the use of patient surveys/questionnaires or directly through participation of identified individuals on project steering groups or patient forums.

Key Statement 4
UHL is committed to the training and involvement of Medical Students and F1/F2 doctors in Clinical Audit. UHL follows the Healthcare Quality Improvement Partnership (HQIP) recommendations on involving junior doctors in Clinical Audit (link to document).

Key Statement 5
Each audit plan is reviewed by the speciality audit leads and audit team before approving/registering to ensure wherever possible that the audit:
• is of clinical value & aims to improve patient care by assessing the background given for why the audit is required
• is correctly categorised (Priority 1-4)
• is planned appropriately including proposed methodology
• has clear SMART standards,
• has an appropriate supervisor
• it is not a duplication of another audit already taking place
• links to any previous audits undertaken that are registered on the audit database ensuring actions agreed previously have been implemented before this audit takes place
• can be delivered within the services current resources alongside the other audit priorities that are planned / ongoing within that area
• has the correct governance structure in place (involving the right staff / information governance & ethical issues).

Key Statement 6
All - ‘Ongoing or to start’ clinical audits registered on UHL Audit Database should be reviewed by the audit supervisor each quarter and RAG rated accordingly (as per UHL Clinical Audit Programme Process link).

Key Statement 7
All national clinical audits relevant to the Trust should be carried out and reported in accordance of Trust guidance (link).

Key Statement 8
A summary form (link) must be completed and submitted to the clinical audit team for all audits after each cycle. This will act as the official record of the audit and will be uploaded on the intranet and used for relevant Freedom of information requests.

Key Statement 9
If a Clinical audit identifies a risk to either the patient, staff or Trust the lead CMG / Specialty of the audit must carry out a risk assessment using the UHL general risk assessment form and take action accordingly – see appendix 3.

Key Statement 10
It is the responsibility of the CMGs (via Speciality Audit Leads) to regularly review actions agreed and keep the summaries up to date on SharePoint (or informing the Clinical Audit Team) with details of the implementation of audit action plans or, ensuring that any identified changes are incorporated into relevant business plans as appropriate.

Key Statement 11
All staff must ensure projects are undertaken in-line with the trusts information governance policies and procedures.

7 Education and Training Requirements

7.1 Provision of Clinical Audit training
The Trust will make available suitable training, awareness or support programmes to all clinicians regarding the Trust's systems and arrangements for participating in Clinical Audit. Details of some of the training provided can be accessed via eUHL, from the Clinical Audit Team or via the Clinical Audit intranet page. Bespoke training is available on request for groups and / or individuals.

7.2 Employment and development of Clinical Audit staff
The Trust will support the Clinical Audit Manager in ensuring there are sufficient suitably skilled Clinical Audit staff to support the Trust’s programme of Clinical Audit activity. The Trust will ensure that the Clinical Audit team and lead audit clinicians have access to further relevant training in order to maintain and develop their knowledge and skills.
# Process for Monitoring Compliance

## 8.1 The audit criteria for this policy and the process to be used for monitoring compliance are given in the table below:

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead</th>
<th>Tool</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
<th>Acting on recommendations and Lead(s)</th>
<th>Change in practice and lessons to be shared</th>
</tr>
</thead>
<tbody>
<tr>
<td>The progress of the organisation’s Clinical Audit programmes and its outcomes is</td>
<td>Clinical Audit Manager</td>
<td>The Trust holds a database which is</td>
<td>Quarterly</td>
<td>Quarterly reports to Clinical Audit Committee, CMG Quality Boards and Executive Quality Board and externally by our Commissioners (see appendix 2).</td>
<td>Audit Supervisors Audit Leads</td>
<td>Change in practice and lessons to be shared</td>
</tr>
<tr>
<td>Reviewed and reported quarterly</td>
<td></td>
<td>managed by the Clinical Audit Team. This holds details of Clinical Audit activity which abides by the rules set out in the Data Protection Act. Reports from the database are generated routinely by the Clinical Audit team and uploaded on the intranet or disseminated to the audit leads and Clinical Audit Committee members. The content and status of the mandatory Clinical Audits on the database should be reviewed on a quarterly basis jointly by the Clinical Audit Team and audit leads as detailed in the Audit Programme Process (link).</td>
<td></td>
<td></td>
<td></td>
<td>Change in practice and lessons to be shared</td>
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<td></td>
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<td></td>
<td></td>
<td>Change in practice and lessons to be shared</td>
</tr>
<tr>
<td>The effectiveness of delivering the Clinical Audit programme and the outcomes are</td>
<td>Director of Clinical</td>
<td>Report run from Clinical Audit Database</td>
<td>Annually</td>
<td>Quarterly reports to Clinical Audit Committee, CMG Quality Boards and Executive Quality Board and externally by our Commissioners (see appendix 2).</td>
<td>CMG Management teams Audit Supervisors Audit Leads</td>
<td>Change in practice and lessons to be shared</td>
</tr>
<tr>
<td>reported in the UHL Quality Account also reported in the UHL Clinical Audit annual</td>
<td>Clinical Quality Club</td>
<td></td>
<td></td>
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<td></td>
<td>Change in practice and lessons to be shared</td>
</tr>
<tr>
<td>report.</td>
<td>Clinical Audit Manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Change in practice and lessons to be shared</td>
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9 Equality Impact Assessment

9.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

9.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

10 Legal Liability

10.1 The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

- Have undergone any suitable training identified as necessary under the terms of this policy or otherwise.
- Have been fully authorised by their line manager and their Directorate to undertake the activity.
- Fully comply with the terms of any relevant Trust policies and/or procedures at all times.
- Only depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible clinician it is fully appropriate and justifiable - such decision to be fully recorded in the patient’s notes.

10.2 It is recommended that staff have Professional Indemnity Insurance cover in place for their own protection in respect of those circumstances where the Trust does not automatically assume vicarious liability and where Trust support is not generally available. Such circumstances will include Samaritan acts and criminal investigations against the staff member concerned.

10.3 Suitable Professional Indemnity Insurance Cover is generally available from the various Royal Colleges and Professional Institutions and Bodies. For further advice contact: Head of Legal Services on 0116 258 8960

11 Supporting References, Evidence Base and Related Policies

Healthcare Quality Improvement Partnership [HQIP] - “Template for Clinical Audit Policy”
The Clinical Audit Handbook: Improving the Quality of Health Care, Clare Morrel & Gill Harvey, Bailliere Tindall/Royal College of Nursing

12 Process for Version Control, Document Archiving and Review

This document will be uploaded onto SharePoint and available for access by Staff through INsight. It will be stored and archived through this system.
13 Glossary

HQIP – Healthcare Quality Improvement Partnership
CAC - Clinical Audit Committee
CMG – Clinical Management Group
EQB – Executive Quality Board
Appendix 1 Related documents with links

Clinical Audit Planner (link)
Clinical Audit Summary form template (link)
CMG Audit - Processes & flowcharts (link)
Process for Generating and Managing the UHL Clinical Audit Programme (link)
Clinical Audit intranet site (link)
Clinical Audit Strategy (link)
Speciality Clinical Audit Leads Job description (link)
Clinical Audit Committee Terms of reference (link)

Information Governance guidance relevant to Clinical Audit (under development)
Appendix 2 Clinical Audit Governance & Escalation Framework

Diagram:
- Trust Board
- Quality Assurance Committee
- CMG Quality Boards
  - Speciality audit meetings
- Executive Quality Board
- Clinical Audit Committee

Notes:
- CMG Quality performance reviews

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Appendix 3
UHL Clinical Audit Risk Assessment Process

Clinical audit identifies a risk (to patient, staff or trust) to the CMG / Specialty / Corporate Directorate

Lead CMG / Specialty / Corporate Directorate carry out a risk assessment using the UHL general risk assessment form (available on INsite)

The risk assessment is presented to the CMG/Corporate Directorate Board / Senior Management Team to be approved prior to it being entered on to the Datix risk register

Once the risk assessment has been approved by CMG / Corporate Directorate it is entered on to Datix risk register and reported in line with the requirements set out in the risk management policy

Risk owner updates the risk on Datix risk register until risk is managed to an acceptable level