Lincolnshire Community Health Services NHS Trust

Clinical Audit Policy and Procedures 2018-2021

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Name of originator/author:	Jill Anderson / Jo Gooch
Name of responsible committee/individual:	Debbie Jeffrey/Katy Ward
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Chair: Elaine Baylis QPM
Chief Executive: Andrew Morgan

Clinical Audit Policy and Procedure 2018-2021

Version Control Sheet

Version	Section/Para/ Appendix	Version/Description of Amendments	Date	Author/Amended by
1		Review, revision and re-naming Clinical Audit Policy (P_CIG_01)	1.3.16	J Anderson/J Gooch
2		Review and revision	18.07.2018	D Jeffrey/K Ward
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Clinical Audit Policy and Procedure 2018-2021

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Clinical Audit Policy and Procedures 2018-21

Policy Statement

Background Statement	The purposes of this policy and procedures are to set out a framework for the conduct of clinical audit within the Trust, and to maintain and support a culture of best practice in the management and delivery of clinical audit within the Trust.
Statement	The organisation has adopted the universally accepted definition for both national and local clinical audit as defined by the National Institute for Health and Clinical Excellence (NICE) in their 'Principles for Best Practice in Clinical Audit' 2002 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.
Responsibilities	Compliance with the strategy and policy will be the responsibility of all staff. Managers are responsible for monitoring the application of the policy.
Training	Training will be provided specific to role across all clinical staff.
Dissemination	
Resource implication	
Consultation	

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Appendix 7	Action Plan Template

Lincolnshire Community Health Services NHS Trust
Clinical Audit Policy and Procedure

1.0 Introduction

1.1 The Trust acknowledges the significance of clinical audit as a quality improvement process and as an important mechanism for providing assurance in relation to the provision of safe and effective patient care. The Trust is therefore committed to delivering effective clinical audit in all the clinical services it provides. This document provides a framework to support the following throughout the Trust:

- the conduct of clinical audit
- the promotion of a culture of learning and continuous service improvement that delivers demonstrable improvements in patient care and contributes to meeting the Trust's corporate objectives

2.0 Background and Strategic Objectives

2.1 In order to provide assurance that the services provided by the Trust reflect evidence-based practice and are of a high standard, performance must be measured by Clinical Audit.

2.2 The expectation for healthcare professionals to participate in regular clinical audit was first established in the 1989 Government White Paper, 'Working for Patients'. This has been reinforced and extended by a succession of key national publications, including:

- The New NHS — Modern Dependable (Department of Health, 1997)
- A First Class Service (Department of Health, 1998)
- Clinical Governance — Quality in the NHS (Department of Health, 1999)
- Learning from Bristol: the report of the public inquiry into children's heart surgery at Bristol Royal Infirmary 1984–1995 [the 'Kennedy Report'] (Department of Health, 2002)
- Good Medical Practice (General Medical Council, 2001)
- National Standards, Local Action
- Good Doctors Safer Patients (Department of Health, 2006)
- Trust Assurance & Safety (Department of Health, 2007)
- The NHS Next Stage Review Final Report, High Quality Care For All [the 'Darzi Report'], (Department of Health, 2008)
- Equity and excellence: liberating the NHS
- NHS Litigation Authority Risk Management Standards
- Francis report (2013)

2.3 Since the creation of Standards for Better Health by the Department of Health in 2004, all NHS Trusts have had to make an annual Declaration including their compliance with Standard C5d,

which states that “Healthcare organisations must ensure that clinicians participate in regular clinical audit and reviews of clinical services.”

2.4 In 2008, the Care Quality Commission (then known as the Healthcare Commission) introduced an ‘Engagement in Clinical Audits’ indicator which places the following expectations on NHS Trusts:

- To participate in local and/or national clinical audits of the treatment and outcomes for service users in each clinical directorate covered by the Trust
- To have a clinical audit policy and program related to both local and national priorities with the overall main aim of improving service user outcomes
- To make available suitable training, awareness or support programs to all clinicians regarding the Trust's systems and arrangements for participating in clinical audit

2.5 Nationally and locally there is a commitment to ensuring stakeholder engagement and collaborative working. As such the Trust is committed to:

- Early involvement of clinical managers in the clinical audit process ensuring commitment where any identified changes raise resource implications
- Supporting all Staff in undertaking effective clinical audit
- The principle of involving patients or carers in the clinical audit process either indirectly through the audit of concerns highlighted through complaints and the use of patient surveys or questionnaires or directly through participation of identified individuals in groups or patient forums.
- Partnership working with other local and regional organisations where improvements to the patient journey may be identified through shared clinical audit activity.

2.6 The Trusts key strategic objectives are:

- Providing high quality, safe, personalised care
- Delivering value for money and financial sustainability
- Strengthening our positive reputation
- Leading integration and innovation

The enabling strategy is detailed within the Trust Board Assurance Framework.

3.0 Scope

3.1 This document is directed at all staff who are responsible for overseeing the direction and development of clinical audit within the organisation or who are involved in the clinical audit process.

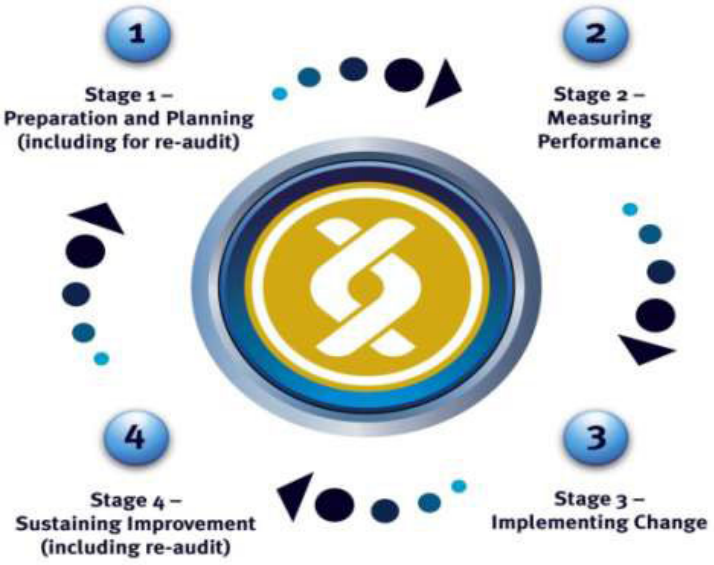
4.0 Definitions

4.1 Clinical Audit

4.1.1 Clinical Audit is one of a number of activities focused on improving patient care. The National Institute for Health and Clinical Excellence (NICE) published 'Principles for Best Practice in Clinical Audit' in 2002 defining clinical audit as:

> '*a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement.'*

Clinical Audit Cycle Fig. 1



4.2 Standard

A standard is the level of care to be achieved for any particular criterion.

4.3 **Criterion**

A criterion is a definable and measurable item of healthcare which describes quality and can be used to assess it.

5.0 Roles and Responsibilities

5.1 **The Chief Executive** is responsible for the statutory duty of quality and takes overall responsibility for this Strategy and policy. In day to day terms the responsibility for clinical governance, of which clinical audit is a key tenant, is delegated to the Deputy Director Quality, Workforce and Education to ensure that systems are in place to facilitate the delivery of safe and effective patient care and for the effective prioritisation of participation in national clinical audit and local clinical audit.

5.2 **The Clinical Audit Group** (a sub group of the Quality Team) is responsible for:

a. Ensuring there are robust processes in place for the effective management if Clinical Audit that meets mandatory NHS Audit Standards and provides independent assurance to the Effective Practice Assurance Group.

b. Ensuring effective structures are in place to support clinical audit that these structures operate effectively and that action is taken to address areas of concern.

c. Approving a programme of National (HQIP, NCEPOD) and Local Clinical audits (this will be maintained as a live audit plan and may be subject to additions during the course of the year), ensuring that all audits are relevant to LCHS.

d. Ensuring the clinical audit function is adequately resourced and has appropriate standing within the organisation.

e. Providing support, leadership, facilitate and manage clinical audit and quality improvement across the Trust that has focus on improving patient clinical outcomes and safe effective clinical practice.

f. Ensuring the data being captured for the audit is appropriate.

g. Promote action to improve the quality and safety of patient care through prioritisation of outcomes identified.

h. Assess new proposals for registration.

5.3 The Clinical Audit Team are responsible for:

- Undertaking the work of the Clinical Audit Group, to include:

- The development of the clinical audit annual plan in collaboration with service audit leads

- Clinical Audit Leads and Managers to monitor delivery of service audit work plans and provide support and advice at Team Meetings where required.

- Advise on developing agendas for the Trust Clinical Audit Meetings to encourage the effective dissemination of audit outcomes, recommendations and improvements to service quality to a trust-wide audience

5.4 **Managers and Service Leads** are responsible for

- Ensuring that service development and delivery is underpinned by clinical audit and forms part of Continuing Professional Development.

- Ensuring completion of the clinical audits to Trust standards and the implementation of change, even when other staff involved leave the organisation.

- Each clinical audit should have a clinical lead that is a senior and permanent Member of staff.

- Data and security and ensuring that the clinical audit project complies with Information Governance.

- Ensuring services priorities, including issues identified from the Risk Register, are reflected in the local annual clinical audit work plan

- Linking revalidation and appraisal to evidence that clinicians have undertaken and completed audit activity

- Ensure significant risks identified through clinical audit are addressed or identified on the directorate Risk Register

- Supporting the development of realistic action plans to improve patient care

5.5 **Clinical Audit Leads** are responsible for:

- Co-ordinating audit activity within their service

- Ensuring, with the support of the Clinical Audit Team, that the audit cycle is completed with action plans developed to address any identified deficiencies, changes implemented and service re-audited as appropriate

- Escalating significant risks identified through clinical audit to the responsible Trust Audit Lead, service lead and Head of Clinical Services. (**Appendix 1**)

- Encouraging participation in national audits / data collection and ensuring that action plans are developed to address any deficiencies identified

- Encouraging multidisciplinary audit and involvement of all stakeholders at the audit design stage. Organising departmental audit meetings to ensure lessons learnt are effectively disseminated, maintaining records of these meetings and ensuring the audit work plan is updated.

- Attending the Clinical Audit Group meetings and providing regular updates on the nominated audits.

5.6 All **Clinical Staff** are responsible for:

- Ensuring they audit their own practice in accordance with their professional codes of conduct

- Conducting clinical audit in accordance with this policy and procedure

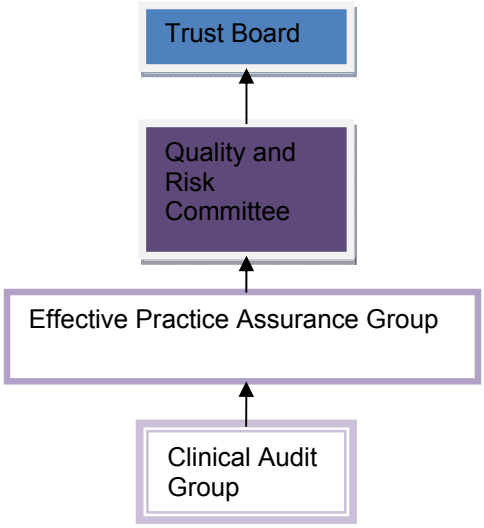
- Taking account of lessons learnt and making changes to service provision where appropriate

- Participating in relevant National Clinical Audits / NCEPOD studies

- Undertaking a gap analysis in response to publication of National Audit reports when identified as the clinical lead and developing an action plan to address any identified deficiencies in accordance with the Implementation of National Guidance Policy

6.0 Accountability

6.1 Clinical audit is a significant mechanism for providing assurance on the quality of services provided. This responsibility is delegated by the Trust Board to Effective Practice Assurance Group, which receives the Clinical Audit Annual report, the Annual Clinical Audit Plan and regular reports.



7.0 Process for Setting Priorities for a Clinical Audit Programme including participation in national and local Audits

7.1 Agreeing an annual programme of activity

7.1.1 Prior to the start of every financial year, the Trust will agree an appropriate planned program of clinical audit activity. This program should meet the Trust's corporate requirements for assurance, but must be owned by clinical services. The proposed program will be prepared by the Quality Team. The annual program is ratified by Quality & Risk Group. The Trust will take a consultative approach to the development of the audit plan. This consultation will seek input from:

- Clinical Audit Group
- Quality Team
- EPAG
- Safeguarding & Patient Safety Committee
- Quality and Risk Committee including Executive Directors and Non-Executive Directors to ensure any clinical audit requirements associated with the organisational objectives are given due consideration.

7.1.2 A Trust Clinical Audit Plan will be developed annually to take account of the following Trust priorities:

- Participation in relevant national clinical audits
- CQC and other regulatory or legislative audit requirements
- Audit of relevant national guidelines including NICE
- Clinical audit topics that align with Trust priorities or have been identified as clinical governance priorities will be included.
- Key local and national patient safety and quality issues

7.1.3 The Trust is committed to supporting other locally determined clinical audit activity as a significant contributor to the continuous process of service improvement. It is acknowledged that individual clinicians may initiate a clinical audit project on the basis of personal interest, personal development or as part of an educational or training program.

7.1.4 The draft annual Trust plan will be approved by the Clinical Audit Group and submitted to the Quality and Risk Committee who will act on behalf of the Trust Board in agreeing the planned programme of clinical audit activity.

7.2 Choosing and prioritising clinical audit projects

There are many reasons why clinical audits are undertaken, although in essence there are two main drivers: quality improvement and quality assurance. Within the Trust, clinical audit resources are finite, and as such clinical audit resources will be restricted to projects with measurable standards and criteria that are expected to deliver improvement and assurance according to agreed Trust priorities.

7.2.1 The Trust supports additional local clinical audit activity as a significant contributor to the continuous process of quality improvement. It is acknowledged that individual clinicians may initiate a clinical audit project at any point in the year on the basis of clinical concerns, personal interest or as part of an education or training programme. It is important that these are registered with the Trust and reported through existing clinical governance structures to maximise organisational learning.

7.2.2 Resources for audit activity are limited. The Clinical Audit Group and service leads must therefore ensure the appropriate prioritisation of audit projects and service Clinical Audit Work plans.

7.2.3 Resources should be utilised to prioritise activity as follows:

Category for Clinical Audits: HQIP Definition Fig. 2

*Category	** Audit Type	
Category 1 audits, 'external must dos'	• National audits (NCAPOP) • NCEPOD / Confidential Inquires • NICE • CQUIN • CQC • Quality Schedules • DH statutory requirements (e.g. Infection Control Monitoring)	1
Category 2 audits, 'internal must dos'	• Clinical risk • Serious untoward incidents • Complaints • Re-audit	2
Category 3 audits, 'Organisational'	• Local topics important to the 'Organisational'	3
Category 4 audits	• Clinician / professional interest • Educational audits	4

7.2.4 Participation in national audits administered by the National Clinical Audit and Patient's Outcomes Programme and monitored through the Quality Accounts and Care Quality Commission Regulations will be considered a Category Level 1. Participation in National Confidential Enquiry studies will also be a level 1 priority (NCEPOD, CEMACE and CEMACH).

7.2.5 Audit of compliance with national guidance, including NICE guidance or issues relating to risk management, will be considered a Category 2 priority.

- Clinical audits of NICE Guidelines
- Clinical audits resulting from gap analyses following the publications of practice recommendations by the National Confidential Enquiry into patient Outcome and Death (NCEPOD)

The following should also inform selection of audit topics:

- National Patient Safety Agency (NPSA) Safety Alert Bulletins or Rapid Response Reports;
- Quality issues
- Royal College and other statutory bodies recommendations;
- 'Saving Lives', Health Act 2006;
- NHS Litigation Authority Risk Management Standard requirements;
- New Health Technology Appraisal process;
- New research evidence.

7.3 Choosing and prioritising local clinical audit projects (Category 3)

7.3.1 Local clinical audit topics should be selected to address aspects of care where standards are available and poor performance is suspected. Review of the following may identify the need for clinical audit:

- Trust Risk Assurance Framework;
- Incident reporting - trends
- Staff Surveys
- Clinical effectiveness / Quality concerns;
- PALS & Complaints, Claims and Litigation
- Cost effectiveness concerns
- Practitioner Performance reports e.g. Fitness to Practice, Coroners Reports ;
- Local guideline implementation;
- New procedures / service developments Integrated Care Pathways.
- NHS England Local Intelligence Network for Controlled Drugs

7.4 Quality and Equality Impact Assessment (QEIA) (Appendix 2)

7.4.1 When prioritising local clinical audit activity, the audit topic should reflect at least some of the following indicators:

- High Volume Service
- High Cost procedure
- High Risk – morbidity, disability, mortality
- Potential for change
- Existence of evidence based, clear standards of good practice
- Direct Involvement of patients, linked to service users priorities
- Area of concern / known problems with care – wide variation in practice
- Multi-disciplinary project / Interface project with other agencies
- National Clinical Guideline/Complaints / incidents
- Risk Management
- Patient Carer Feedback
- Commissioning for Quality and Innovation (CQUIN)
- Service Development
- Re-audit
- Baseline Assessment / Monitoring

7.4.2 A Clinical Audit Guide for staff is provided at **Appendix 3**

8 GOVERNANCE OF AUDIT

8.1 Systems for registering and approving clinical audit

8.1.1 All Clinical Audits should be registered with the Clinical Audit Group prior to commencement; using the Clinical Audit Registration form (**Appendix 4**).

- All clinical audit must be discussed with and approved by the appropriate service audit lead in the first instances.
- Any doctors who are training and working within the Trust, wishing to undertake a clinical audit project must do so with the approval of the Medical Director.
- All clinical audit activity must be discussed with, and approved by the CAG.

8.1.2 The Clinical Audit Group will review the information provided on the audit registration form to ensure the proposal complies with good clinical audit practice. Approval must be obtained **before** the clinical audit can commence.

8.1.3 Where possible, routinely collected data from existing sources (e.g. case notes, I.T. systems) should be used. However, in cases where the data is not currently collected or is incomplete, collection of new data may be necessary. In such cases, only data relevant to the clinical audit are to be collected.

8.2 The use of standards and criteria in clinical audit

8.2.1 By definition, clinical audit involves measuring clinical practice against pre-determined standards of best practice. Standards are an agreed statement of best practice which will improve the quality of care, they will usually be broken down into measurable criteria with an expected level of compliance (e.g. 100% of records will contain the service user's date of birth).

8.2.2 Standards should be evidenced based and ideally taken or adapted from sources including national guidance recommendations e.g. NICE, clinical audit criteria, network or local guidelines and policies.

8.3 Equality and diversity

8.3.1 The process for determining choice of clinical audit projects, and the manner in which project service user samples are drawn up, must not inadvertently discriminate against any groups in society based on their race, disability, sex, age, sexual orientation, gender reassignment, religion and belief.

8.3.2 All relevant local policies will have an equality impact assessment which should provide guidance to those developing clinical audits to ensure that discrimination is avoided.

8.4 Information governance: collection, storage and retention of data and confidentiality

8.4.1 All clinical audit activity must take account of the General Data Protection Regulation (GDPR) 2018 and the Caldicott Principles (1997). This means, for example, that data should be:

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

8.4.2 Clinical audit activity must also conform to the requirements of the NHS Confidentiality Code of Practice (2003) which states that “Patients must be made aware that the information they give may be recorded, may be shared in order to provide them with care, and may be used to support local clinical audit”.

8.4.3 Service user identifiable information should **NOT** be collected as part of a clinical audit. All clinical audit data should be anonymised for patients, service users and staff. This means that identifiable data such as name, address, postcode, date of birth, and any other combination of details that may identify the individual are removed. Special care will need to be taken when auditing areas where there are relatively few clinical cases, and individuals could be identified more easily.

8.4.4 Where the clinical audit involves the service user being contacted to complete a clinical audit questionnaire, the department concerned must write out to service users, explaining what the clinical audit is, the reason for the clinical audit and to whom the information may be disclosed to.

8.5 Clinical audit database

8.5.1 The Clinical Audit Team will maintain a database with details of all clinical audit activity reported to them. The database will include key information from the Audit registration document, including the name and contact details of the audit lead.

8.5.2 The database will support the monitoring of clinical audit program. Progress and data held will be used as part of governance reporting arrangements and this is why it is vital that all clinical audit activity is logged with the Clinical Audit Group.

8.5.3 Audit Monitoring process

Appendix 5 provides the template for monthly reporting of audits and the actions required where audits have failed to progress.

8.6 Ethics and consent

8.6.1 By definition, clinical audit projects do not require formal approval from a Research Ethics Committee, but must be conducted within an ethical framework to ensure that no harm is caused to service users or staff and data collection is reliable.

8.6.2 Every clinical audit should conform to the following four principles:

- There is a benefit to existing or future service users or others that outweighs potential burdens or risks.
- Each service user's right to self-determination is respected.
- Each service user's privacy and confidentiality is preserved.
- The activity is fairly distributed across service user groups.

8.6.3 In cases where the clinical audit is investigating a sensitive area or asks staff/service users sensitive, intrusive questions, the clinical audit must be discussed with the Clinical Audit Group who may seek advice from other relevant staff within the Trust.

8.6.4 When conducting a clinical audit that involves direct contact with service users / carers, all staff must ensure they are approached in a sensitive and respectful manner, they should be given a full written explanation (which needs approval from the Clinical Audit Group, advice may be sought from Information Governance as appropriate) as to the purpose of the clinical audit, should be assured about confidentially and the length of time their data will be held and be given the option not to take part in the clinical audit.

8.6.5 No clinical audit will examine the work of another professional or specialty without their knowledge. Suitable stakeholder selection of key members of staff within professions or specialty will ensure dissemination of clinical audit information to relevant staff.

9 REPORTING AND DISSEMINATING RESULTS

9.1 Reporting

9.1.1 A Clinical Audit Report template, including guidance on what should be included in the Report, can be found at (**Appendix 6**).

9.1.2 Completed reports should be sent to the Clinical Audit Group and should include an action plan produced from clinical audit recommendations. These will be used when reporting governance information about clinical audit activity within the Trust. The Author of the report will be required to

present the audit findings and action plan to the Clinical Audit Group in person or via teleconference.

9.1.3 *Cases of unacceptable care* should be escalated as appropriate and reviewed in order for the team to:

- Clearly identify and agree on areas for improvement identified by the audit.
- Analyse the areas for improvement to identify what underlying, contributory or deep rooted factors are involved.

9.1.4 *Excellence in Practice*
Clinical audit results may show areas of excellent or 'notable practice' and this should be acknowledged. Reports will be presented to the Clinical Audit Group to enable dissemination of best practice.

9.2 Clinical audit annual report

9.2.1 An Annual Clinical Audit Report will be produced by the Quality Team. It will include outcomes and conclusions from clinical audits, together with an update on the implementation of action plans. This report will be approved by the Quality & Risk Group for dissemination to staff and will be available on the staff intranet.

10 ACTION PLANS AND IMPROVEMENT

10.1 Action plans (Appendix 7)

10.1.1 The main purpose of clinical audit is to deliver improvements in clinical practice. Where the results of a clinical audit indicate sub-optimal practice, an action plan must be produced and approved through the Clinical Audit Group. The **escalation process** should be followed at **Appendix 1. Significant risks** identified through clinical audit, should be **immediately** escalated to the Head of Clinical Services (or Deputy if unavailable), Service Lead and Trust Audit Lead.

10.1.2 Action plans should be specific, measurable and achievable/realistic. They should have clear implementation timescales with identified leads for each action. Action plans should also have been approved by the relevant head of service or department.

10.1.3 Where an audit shows that **ALL** standards are being met, there will be no need for an action plan, however, such clinical audits must have an explicit statement saying 'no further action required' in the clinical audit summary report and a reason given for no re-audit.

10.1.4 Audit leads are responsible for ensuring the identified changes are incorporated into practice and relevant business plans. Services are responsible for the implementation and monitoring of action plans, which will be followed up in local Service Line governance groups.

10.2 Re-audit

10.2.1 Re-audit is important to determine whether agreed actions have been implemented according to the action plan and have made a quantifiable difference. The Clinical Audit Group will support forward planning of re-audits when timescales have been given.

11 MONITORING EFFECTIVENESS

11.1 Monitoring the effectiveness of clinical audit activity

11.1.1 The Clinical Audit Group will ensure that all projects approved by them comply with this policy. Audits that do not comply will not be approved.

11.1.2 The lead for approved clinical audits will submit an audit report and action plan to the Clinical Audit Group one month after completion. The Clinical Audit Group will monitor the progress on the implementation of actions plans via Heads of Clinical Services, updates at agreed time intervals.

11.1.3 Any action plans that are not being implemented or resource or governance considerations will be escalated to the Effective Practice Assurance Group (EPAG) for consideration and resolution or further escalation.

11.1.4 The following is a list of standards / indicators that will be monitored by the Clinical Audit Group and reported in the Clinical Audit Group Annual Report and for the Trust's annual Quality Account reporting:

Indicators:

- Number of clinical audits registered with the Clinical Audit Group within the year
- Number of clinical audits registered by service
- Number of national, regional and local clinical audits registered.

Standards:

- 100% of clinical audits undertaken will have approval from the Clinical Audit Group
- 100% of approved clinical audits will have a report submitted
- 100% of approved clinical audits will have an action plan submitted OR best practice confirmed
- 100% of approved clinical audit projects will meet national AND organisational priorities
- participation in relevant National Clinical Audit and Patient Outcomes Program
- 20% of approved clinical audit projects which will cross over to other teams
- 100% of abandoned clinical audits have a documented reason for abandonment.

11.1.5 The Quality & Risk Group will review and approve the annual Clinical Audit Report which will include details of clinical audit activity throughout the Trust, details of changes to clinical practice and impact of the clinical audit program on service user care.

11.2 Monitoring effectiveness of the policy

11.2.1 This Clinical Audit Policy and Procedure will be reviewed every three years. However, should National guidance or legislation change then the policy may be reviewed earlier.

11.2.2 As part of the policy review process, the effectiveness of the policy and its application will be assessed. Information and results from clinical audit systems, adverse incidents, user feedback and external clinical audits / reviews will be used to inform this assessment. This will be performed by the Clinical Audit Group in association with the Quality & Risk Group.

1 2 REFERENCES

NICE (2002) Principles for Best Practice in Clinical Audit. National Institute of Clinical Excellence. Available at: http://www.nice.org.uk/usingguidance/implementationtools/auditadvice/

Data Protection Act (1998) Available at: http://www.ico.gov.uk/what we cover/data protection/legislation in full .aspx

Caldicott Principles (1997) Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH 4068403

NHS Code of Confidentiality (2003) Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH 4069253

Records Management – NHS Code of Practice (2006) Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH 4069253

Lincolnshire Community Health Services NHS Trust

NHSLA Monitoring Template

This template should be used to demonstrate compliance with NHSLA requirements for the procedural document where applicable and/or how compliance with the document will be monitored.

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individuals/group /committee	Frequency of monitoring /audit	Responsible individuals / group / committee (multidisciplinary) for review of results	Responsible individuals / group / committee for development of action plan	Responsible individuals / group / committee for monitoring of action plan
Annual Review of Clinical Audit Management Process Monthly Review of Risks	Board Reports Review of Strategy/Risks Confirm and Challenge	LCHS Board Trust Executive Group Effective Practice Assurance Group Quality & Risk Group Clinical Audit Group Other formal Committees as appropriate	Annual auditing of Clinical Audits	LCHS Board Trust Executive Group Effective Practice Assurance Group Quality & Risk Group Clinical Audit Group Other formal Committees as appropriate	LCHS Board Trust Executive Group Effective Practice Assurance Group Quality & Risk Group Clinical Audit Group Other formal Committees as appropriate	LCHS Board Trust Executive Group Effective Practice Assurance Group Quality & Risk Group Clinical Audit Group Other formal Committees as appropriate

Equality Analysis

Name of Policy/Procedure/Function*	
Equality Analysis Carried out by:	**Katy Ward**
Date:	
Equality & Human rights Lead:	**Rachel Higgins**
Director\General Manager:	**Dr Yvonne Owen**

***In this template the term policy\service is used as shorthand for what needs to be analysed. Policy\Service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.**

Section 1 – to be completed for all policies

A.	Briefly give an outline of the key objectives of the policy; what it's intended outcome is and who the intended beneficiaries are expected to be	The purposes of this policy and procedures are to set out a framework for the conduct of clinical audit within the Trust, and to maintain and support a culture of best practice in the management and delivery of clinical audit within the Trust.		
B.	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? **Please give details**	No		
C.	Is there is any evidence that the policy\service relates to an area with known inequalities? **Please give details**	No		
D.	Will/Does the implementation of the policy\service result in different impacts for protected characteristics?	No		
		Yes	No	
	Disability		√	
	Sexual Orientation		√	
	Sex		√	
	Gender Reassignment		√	
	Race		√	
	Marriage/Civil Partnership		√	
	Maternity/Pregnancy		√	
	Age		√	
	Religion or Belief		√	
	Carers		√	
	If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2			
The above named policy has been considered and does not require a full equality analysis				
Equality Analysis Carried out by:		Katy Ward		
Date:		30.07.2018		

Appendix 1

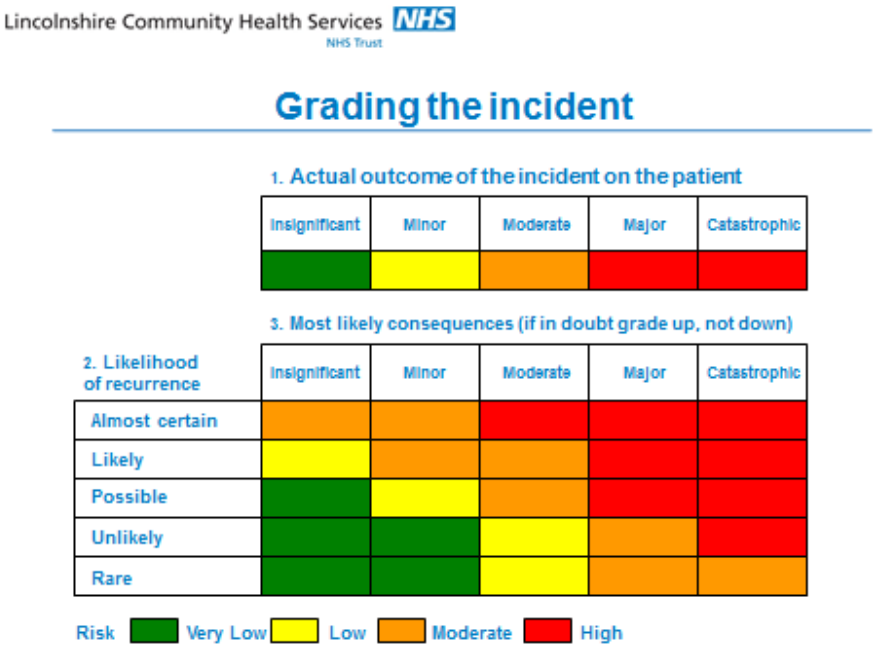
Audit Escalation Process

Performance Levels not reached

The basic requirement for an audit is to identify whether or not performance levels have been reached.

Risk – identified

Where risk is identified through clinical audit, this should be **immediately** escalated to the Head of Clinical Services (Deputy if unavailable), Service Lead and Trust Audit Lead. Risk assessment should be undertaken to determine the level of risk and the action required, using the Trust Risk Assessment Matrix



Where appropriate, risks will require entering onto the Trust Risk Register and action plans completing within agreed time frames.

High Risk	Immediate Action
Moderate Risk	Urgent action - within 2 weeks
Low Risk	Action within 4 weeks
Very low Risk	Action time-frame to be defined by Clinical Audit Group in conjunction with Service leads, Heads of Clinical Services.

Failure to achieve compliance

In order to understand the reason for failure to achieve compliance with clinical audit criteria, the audit team should review all findings. Individual cases where care is not consistent with criteria should be reviewed to find any cases which may still represent acceptable care.

Cases of unacceptable care should then be reviewed in order for the team to:

- Clearly identify and agree on areas for improvement identified by the audit.
- Analyse the areas for improvement to identify what underlying, contributory or deep rooted factors are involved.

There must be clear understanding of reason why performance levels are not being reached to enable development of appropriate and effective solutions. There are a number of tools (see Investigatory Framework) that can be utilised to facilitate a root cause analysis, including process mapping, the 'five whys', SHELL model and cause and effect diagrams (fishbone).

This should clearly identify:

- Areas for improvement, e.g. unrecorded practice, practice not occurring, poor levels of service user satisfaction
- Causes, e.g. poor documentation, inadequate staffing, training and practice issues.
- Needed improvements e.g. introduction of structured assessment pro-forma
- Information explaining why some cases do not meet the required standards
- Relevant, meaningful and useful information that will help to identify and address issues arising from the audit.

By establishing the reasons why performance levels for specific criteria were not met, the team are then enabled to discuss / lead recommendations for improvement and put appropriate action plans in place (**Appendix 7)**

Appendix 2

Quality and Equality Impact Assessment

It is fully recognised that there is a need to maintain a degree of locally initiated projects. These projects often cannot be determined at the outset of the financial year. They represent innovative ideas from clinicians and can provide valuable educational experience for junior staff. All this leads to the need to develop a transparent system for decision making about whether or not (and to what extent) a locally conceived project should be undertaken. The list below provides criteria (weighted for importance) in scoring projects for priority.

Score Issue	No relevance (0)	Some relevance (1)	Almost met (2)	Fully Met (3)	Score
High volume					
High cost					(x2)
High risk					(x2)
Potential for change					(x2)
Existence of evidence base					(x2)
Direct involvement of patients					
Wide variation in practice					
Multidisciplinary project					
Interface project					(x2)
Total score					

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 3

Clinical Audit Guide
(Revised June2018)

1. What is clinical audit?

Clinical audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. This is done by measuring the care and services provided against evidence base standards, changes are implemented to narrow the gap between existing practice and what is known to be best practice. Ideally, a clinical audit is a continuous cycle that is continuously measured with improvements made after each cycle and should be viewed as an integral part of working practice.

HQIP (Healthcare Quality Improvement Partnership) definition of 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'. **Burgess R (ed). New Principles of Best Practice in Clinical Audit, Radcliffe, 2011.**

2. The benefits of clinical audit

Increases:

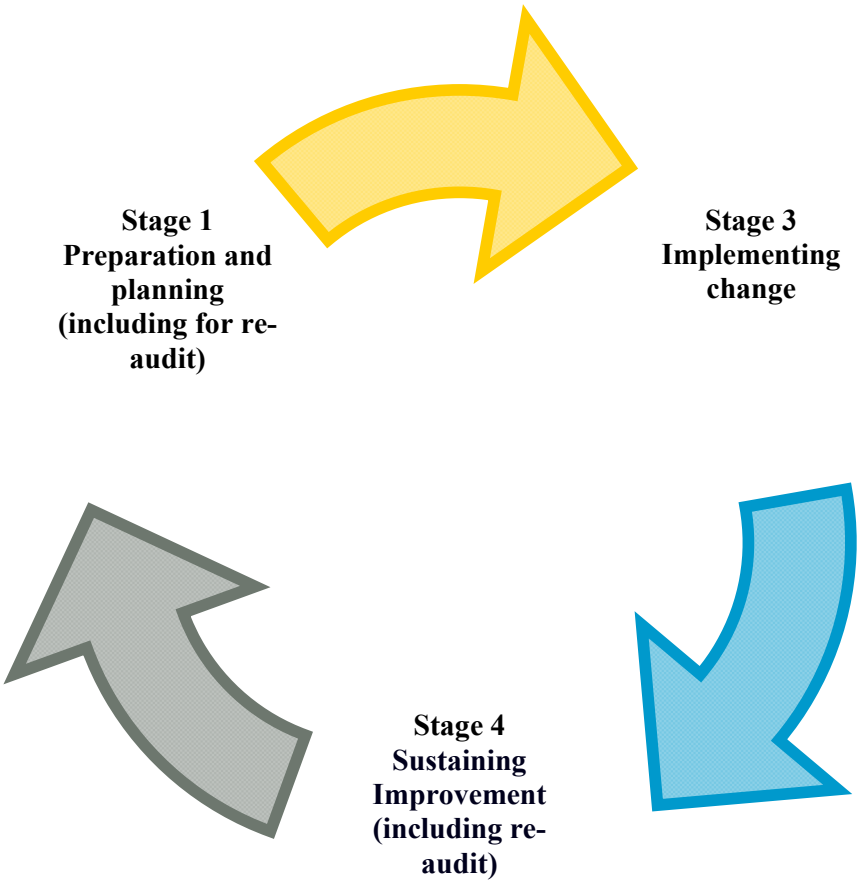
- Improves efficiency
- Improves patient care
- Improves effectiveness
- Ensures delivery of best practice
- Promotes higher standards of hospital and community care
- Brings about change
- Aid to continuous education
- Efficient use of resources
- Accountability to those outside the profession
- Meeting patients' needs and expectations

Decreases:

- Reduces frustration
- Reduces health inequalities
- Reduces organisational and clinical error

3. The clinical audit cycle

HQIP have identified that clinical audit has to have four essential stages of activity to be considered high quality



Stage 1: Preparation and planning (including for re-audit)

1. **The topic for clinical audit is a priority**:

1.1 The clinical audit topic reflects a local service, specialty or national priority where care could be improved or refined through clinical audit.

1.2 The key stakeholders agree, both clinical and non-clinical agree that the clinical audit topic is a priority.

2. The clinical audit measures criteria against standards:

2.1 The clinical audit criteria are based upon the best available evidence e.g. NICE guidance, national guidelines. Some national clinical audits will have a role in defining or refining criteria.

2.2 The clinical audit criteria are referenced back to their source

2.3 The clinical audit criteria are expressed in a form that enables measurement e.g. SMART – specific, measurable, achievable, relevant and timely.

3. The organisation agrees the clinical audit:

3.1 Staff should have time to participate fully in the clinical audit. As far as possible, clinical audit work should be embedded into routine work of clinicians. If clinicians are required to give time over and above normal practice, this must be identified on the audit registration form and staff given protected time to participate.

3.2 Any necessary training to conduct the clinical audit is identified and provided.

3.3 Clinicians with senior responsibility for the area of healthcare being audited show commitment to the clinical audit and provide the necessary leadership.

3.4 There is ownership of the clinical findings at the most senior management level. Responsibility to enact change resulting from clinical audit is accepted by those who can implement change.

4. Patients or their representatives are involved in the clinical audit if appropriate:

4.1 The patient group to whom the clinical audit standards apply is clearly defined.

4.2 The clinical audit standards take full account of patient priorities and patient defined outcomes e.g. the clinical audit incorporates Patient Reported Outcome Measures (PROMS).

4.3 Patient/carers are recognised as key stakeholders in the clinical audit process. If appropriate and feasible, patient representatives and relevant organisations are involved in the clinical audit governance, treated as stakeholders and where appropriate, in all stages of the clinical audit cycle as equal members of the audit team.

4.4 If required, patients who are members of the clinical audit team are given basic clinical audit training to enable them to contribute effectively to the clinical audit process.

4.5 Patients are kept informed throughout the clinical audit process about timescales, progress, results and actions.

Stage 2 – Measuring performance

5. The clinical audit method is described in a written protocol:

5.1 The timetable for the clinical audit is described in the Registration Form and Audit Tool, including timescales for completion and re-audit where necessary.

5.2 The protocol describes the methodology and data collection process in detail.

5.3 Consideration is given to data confidentiality and consent issues, and Caldicott principles are applied. Clinical audit should not require approval from a research ethics committee.

5.4 The methods used in the audit are recorded so that re-audit can be undertaken later in the audit cycle.

6. The target sample should be appropriate to generate meaningful results. (see further guidance in Appendix 1)

6.1 If a sample of the population is to be audited then the method for sampling is that which is best suited to measuring performance against the standards and, as best as possible, scientifically reliable.

6.2 The sample size is sufficient to generate meaningful results.

7. The data collection process is robust:

7.1 The clinical audit uses pre-existing data sets where possible, however these should be used with caution depending on their reliability.

7.2 The data collection tools and processes have been validated e.g. using data collection tools that have already been proven for the type of audit.

7.3 The data collection process aims to ensure complete capture of data. This should demonstrate full case ascertainment and full case completion of each case within the audit. Any excluded data should be explained.

8. The data are analysed and the results reported in a way that maximises the impact of the clinical audit:

8.1 Data are analysed and feedback of the results is given so that the momentum of the clinical audit is maintained in line with the agreed timetable.

8.2 Results of the clinical audit are presented in the most appropriate manner for each potential audience to ensure the results support action planning.

8.3 The results are communicated effectively to all key stakeholders, including to patients.This can be through presentations at meetings, in written reports, posters etc. but should be in such a format as to be easily understood.

Stage 3 – implementing change

9. An action plan is developed and implemented to take forward any recommendations made:

9.1 The clinical audit results are written into a plan which sets out the areas needing improvement and where there is good compliance, recommends the actions to address the identified issues and sets out how these will be implemented. Recommended actions should be targeted at service team, managerial or organisations level where possible.

9.2 The action plan has 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. Any barriers to implementing changes should be identified in the plan and action to be taken to address them.

9.3 The plan identifies who is responsible for taking each action and by when, and when achievement of the actions will be reviewed.

9.4 The plan identifies any financial or other resource implications associated with the recommended actions.

9.5 Implementation of the action is closely monitored and progress regularly communicated to stakeholders. Timetables need to be set and those with responsibility will oversee and drive the implementation of the action plan

Stage 4 – Sustaining improvement (including re-audit)

10. The clinical audit is a cyclical process that demonstrates that improvement has been achieved and sustained.

10.1 The topic is re-audited to complete the audit cycle, where necessary. Re-audit can measure continuing compliance with the clinical audit standards, confirm that recommendations arising from the initial audit have been implemented, or measure that good practice has been maintained. In some cases re-audit may not be necessary or possible e.g. if all standards are met in the first audit or there have been significant structural change.

10.2 The results of the re-audit are recorded and disseminated appropriately

4. Audit Pathway

The Clinical Audit Pathway includes 2 flowcharts; one describes the steps that must be followed during the entire Clinical Audit process and the other flowchart describes the audit support available to access from the Research & Clinical Audit Department. Please click on the link below to access this document or see pages 8 and 9.

\\Fsnl2\lchs\2018-2019\Secure (LCHS)\Quality and Risk Team\Clinical Audit\Documentation templates\Clinical Audit Pathway V4.docx

Audit Process

Completion of Audit Registration form
Decide on tool to use and which policy/SOP it is going to be testing e.g. NICE, SOP/Policy/Standards

Management approval
Discussion and approval of audit with Manager and at Team meeting

Submission of Registration Form for Quality Check
The Registration form and Audit Tool will be submitted to the Clinical Audit Team for quality-checking, reviewing and approving. Submission will be to the Research & Clinical Audit team generic e-mail:
ClinicalAudit@lincs-chs.nhs.uk

Quality Assurance Group Agreement
Clinical Audit will be submitted to the Quality Assurance Group/governance group for agreement.

Addition of audit to Clinical Audit Register
Once approved, the audit will be added to the Clinical Audit Register and will notify the Clinical Team that the audit can proceed.

Start of Audit
Once officially approved by the Research and Clinical Audit Group, the audit will commence.

Ongoing monitoring
The Clinical Audit Team will contact the Audit Lead to request an update on progress of the audit and to remind the audit team to forward the results, report and action plan to the Clinical Audit team generic e-mail address.

Presentation and Discussion of Results
Clinical team will present the results to the Team meeting where the results themselves may raise other questions/additional actions. (Tool to be adjusted as necessary for re-audit.)

Report and Action Plan
Produce an Audit report and Action Plan using Trust templates and report to the Quality Service Line Assurance/Governance group, either Urgent Care or Community as appropriate. This will include details about how the results informed the action plan.

Report to Clinical Audit Team
Audit report and Action Plan to be sent to the Clinical Audit Team.

Record completion of audit
Clinical Audit tracker updated and report discussed at the Clinical Audit Committee.

Re-audit
Decide on re-audit and submit to the Clinical Audit Team to be added onto the Clinical Audit Register.

Accessing Audit Support

Advice

Contact Research & Clinical Audit Team at clinicalaudit@lincs-chs.nhs.uk for advice or for completion of the Clinical Audit Registration form or audit tool.

Audit Planning Tools and Support

Research & Clinical Audit Team are available at all stages to give advice on the following:

a) standards to be audited against (NICE, National Audit, SOP, Policy)
b) developing audit tools
c) data collection methods (methodology)
d) completion of clinical audit registration form.
e) arrange for audit training and signposting to useful resources eg the National Clinical Audit and Quality Improvement Network

Taking your audit through the approval process

Once the Registration Form is received, the Research & Clinical Audit team will:

1) Take it through the Trust approval process

Ongoing support available

Advice and support is available throughout the audit process to completion.

Reporting

- **Support and advice is available to enable the production of reports and action plans for the clinical quality teams.**
- **The Clinical Audit Team will provide tracker reports to show progress against the Clinical Audit Plan.**
- **The Clinical Audit Team will collate the outcomes and improvements from the reports that have been presented at the Quality Assurance Group meetings and will present and report them to EPAG.**

Appendix 1 – additional guidance on the audit process

1a. Registering your audit

The audit registration form and audit tool must be completed and submitted to the Clinical Audit Team for quality-checking, reviewing and approving, please click on the link below for the registration form. Once agreed, your audit will be added to the annual clinical audit programme.

\\FsnI2\lchs\2018-2019\Secure (LCHS)\Quality and Risk Team\Clinical Audit\Documentation templates\Clinical_Audit_Registration_Form_V5_.doc

1b. Types of audit

Outcome audit asks what the result of the care delivered was. Used to assess if patients get the appropriate outcome e.g. blood pressure control of diabetic patients.

Process audit asks what care was delivered. Refers to decisions and actions taken e.g. do patients get the right treatment at the right time.

Structure audit asks how care is delivered. Looks at items required for clinical practice e.g. equipment, materials.

1c. Selecting a topic

It is advisable to choose a topic which encompasses as many of the following as possible:

- It is a priority
- It is of concern to service users and has potential to improve service user outcomes
- It is of clinical concern e.g. an acknowledged variation in clinical practice, high risk procedure
- It is financially important e.g. very common, very expensive
- It is of local and/or national importance
- It is practically viable e.g. can be measured and you will be able to implement change or effect the implementation of change
- There is new research evidence available

Id. Audit objectives

Having decided on the audit topic it is helpful to clearly define your clinical audit objectives. That is why you are doing the audit and what will be achieved as a result.

Example

Clinical audit topic:

Preparation of families for multi-professional assessment appointment

Objectives:

1. To confirm whether parents/carers are sent an information leaflet prior to assessment appointment
2. To confirm whether parents/carers receive a telephone call from a member of the team prior to their assessment appointment
3. To determine whether the parents/carers feel adequately prepared for assessment as a result of the leaflet and telephone call

1e. Setting audit criteria and standards

A criterion is a statement that is used to assess the appropriateness of health care decisions, services and outcomes. Criteria should be evidence based, agreed by the audit team and unambiguous and clear.

A standard is expresses as a percentage and defines the level of performance considered acceptable in relation to the chosen criterion. Standards need to be achievable.

Example:

Criterion	**Standard**
Children referred will be seen with two weeks of the referral being received	**95%**

1f. Data collection

Most data collected for clinical audit are quantitative. It can also be useful to collect some qualitative data to increase understanding of complex areas (e.g. service users' views). More time tends to be required for the analysis of qualitative data than quantitative data.

1g. Sample size

An audit usually involves a defined group of people who share certain characteristics such as the same medical condition or having received the same type of treatment. Ideally the care received by all the audit population should be audited, however this can be impractical.

For most audits a 'snapshot' sample will be sufficient – this should be small enough to allow rapid data collection but large enough to represent the audit population.

Example:

If there were 20 patients in the defined group then it would not be appropriate to take a sample of 20% (4 patients)

If there were 200 patients in the defined group then it would be appropriate to take a 20% sample (40 patients)

If a greater accuracy in the results is required a sample size should be calculated that is representative of the whole audit population. Sample size calculations depend on: the size of population; the degree of accuracy required; the degree of confidence required; and how often the audit criteria are expected to be met. There are a number of sample size calculators and guides available detailing how to choose sample sizes depending on these criteria. Advice on which is the best sample size for a specific audit can be sought from your audit lead or quality governance manager.

1h. Reporting

The trust has a standard reporting template to be used on completion of the audit, please click on the following link to access this document.

\\Fsnl2\lchs\2018-2019\Secure (LCHS)\Quality and Risk Team\Clinical Audit\Documentation templates\Clinical Audit Report Template V.2.0.doc

Appendix 2

Data Collection Tool Example

Questions	Y	N	N/A	Total (%)	RAG	Action
Process 1 (paragraph 5.6)						
1 -	8	2		80		
2 -	5	5		50		Action plan
3 -	3	7		30		Action plan
4 -	6	4		60		Action plan
5 -	9	1		90		
TOTAL	**31**	**19**		62		Action plan
Process 2 (paragraph 5.7)						
1 -						
2 -						
3 -						
4 -						
TOTAL				75		

RAG rating	
% range	**Rating**
<50	
51-74	
>75	

Appendix 4

AUDIT REGISTRATION FORM **(revised July 2018)**

For office use

To prevent delay in review and approval of your audit, it is important to answer all the following questions.

Audit Title:		
Name and delegation of person leading on the audit:		
Names of the rest of the team to be involved in the audit:		

Multi-professional
It is recommended that wherever possible a new member of staff or junior member of staff is included in the audit team to add perspective of testing and challenging comprehensive and non-ambiguous processes. Projects have a greater chance of success if all staff affected by the project or the changes identified are involved from the start. Please consider whether and how the following people should be included:

GPs/Doctors	
Nurses	
Allied Health Professionals	
Others: (Specialist nurses, Medicines Management, IP&C Team)	

Please detail the sites (name of Hospital(s), ward, clinic) **where the audit will be taking place:**		
Please detail the service area that the audit will be covering e.g. Meds management; infection control; urgent care		
Please detail the Business Unit that the audit will be covering?		
Date registration form completed:		
Is this audit being registered as :	**New**	**Re-audit**
Is the audit: **Refer to Appendix 1 for definition of retrospective and prospective**	**Retrospective**	**Prospective**

Tick the source of the audit and specify the standards that the audit will be testing:

Source of audit:	**(please tick)**	**State the specific standards that the audit will be testing/measuring:** *(Why has it been chosen, what makes it a priority?)*
External:		
National Guidelines/Audit		
External Recommendation		
NICE compliance		*Eg. NG53*
Other external (please specify)		
Internal:		
Best Practice		
KPI's/CQUIN		
As a result of a complaint or incident		
Assessment/monitoring		
Service development		
Area of concern		
Other internal (please specify)		

SCOPE:

What standards (criterion= target) are you going to measure, what is the aspect of care that you are going to examine and what target are you going to set for each criterion (proportion of occasions or patients which must fulfil each criterion, usually a percentage)
(see Appendix 1 for example)

Criterion (care aspect)	**Target (%)**
E.g. Drugs administered to patients should be in date	*100%*
Paragraph 5.4……	*75%*
Paragraph 5.5	*75%*

Please specify which of these questions are potentially high risk ie. those where 100% is expected:

Please provide further detail about how the methodology for your audit ie your sample size, target group,

data collection methods and describe the objectives of your audit:

Type of record to be audited (electronic /hard copy)	
What kind of records will be accessed for the audit?	*(Eg. System 1, module x, patient notes)*
Is the audit 'prospective' or 'retrospective'? *(please refer to Appendix 1 for definitions)*	
Sample Size overall/by site?	
Proposed period of data collection:	
Proposed start date:	
Planned end date:	
Planned date for completion of report (*this date will be added to the clinical audit reporting cycle)* :	

Please provide information regarding dissemination of results:

How will learning be disseminated to all staff through their internal and external groups?	
Relevant Committee(s) at which audit findings report to be presented: *(e.g. Medicines Management/ IP&C/ Safeguarding/Quality Scrutiny Group)*	
How will this audit improve outcomes for patients?	

Please provide the category of the audit you want to carry out by referring to the examples provided under each Level and putting a tick against the category your audit is aligned to.

Category of Audit	**Please put tick in one box**
Category 1 (External 'must dos') *For example* • *National audits (NCAPOP RCP)* • *NCEPOD/Confidential Inquiries* • *NICE* • *CQUIN* • *Quality Schedules* • *DH statutory requirements*	
Category 2 (Internal 'must dos') *For example* • *Clinical risk* • *Serious untoward incidents* • *Complaints* • *Re-audit*	
Category 3 (Local topics important to the organisation)	
Category 4 (Clinician/professional interest)	

For example *Educational audits*	

Declaration
I undertake to ensure that the project will result in a report and agreed action plan that sets out the changes that will be agreed; it will define time scales for implementation, person(s) responsible and describe how changes will be implemented. Trust templates will be used.

This proposed audit has been discussed and approved by my Team and Manager.

Name of Audit Lead:	
Job Title:	
Signature:	
Please advise how much protected time (if any) you will require to complete the audit?	
Date:	

Name of Manager:	
Job Title:	
Signature:	
Date:	

Please return completed form by email to clinicalaudit@lincs-chs.nhs.uk

Clinical Audit Contact Details:
E-mail address: clinicalaudit@lincs-chs.nhs.uk
Tel: 01522 308808
Address: Research & Clinical Audit Department
Lincolnshire Community Health Services NHS Trust
Beech House
Witham Park
Waterside South
Lincoln, LN5 7JH

Appendix 1

SOP/NICE/CQUIN/National Audit to be audited:					
Process/Paragraph to be audited eg. paragraph 5.3 (Process A)					
	Question	**Y**	**N**	**N/A**	**%**
1.	*Was the referral letter logged onto System 1*				
2.					
3.					
4.					

Process/Paragraph to be audited eg. Paragraph 5.4 (Process B)					
	Question	**Y**	**N**	**N/A**	**%**
1.					
2.					
3.					
4.					

Definition of Prospective Audit and Retrospective Audit

Prospective audit is based on the collection of information about patients during their process of care. It permits more reliable and complete clinical data collection since the data required is pre-defined and can be validated and errors corrected while the data collection is in progress.

Retrospective audit is generally based on review of records of discharged patients. This may provide information that is more representative of day-to-day practice, but it is more difficult to obtain complete data on every subject in the sample. Retrospective audit may make use of computer databases provide the data they contain is of adequate quality.

Audit Monitoring Process -Monthly Reporting Template

Key for Colour-coding of Progress Status

Current Status		Actions
Red	Cause for concern. No progress towards completion.	Reasons identified, action plan requested and timeframe for completion agreed (see below_
Amber	Delayed, with evidence of actions to get back on track	Reasons identified, action plan requested and timeframe for completion agreed (see below)
Green	Progressing on schedule (P), or completed (C) Please indicate with a P or a C	
Blue	Audit not planned to start this month	
Purple	Await publication of National Results	
Black	Audit removed from the audit programme	
Grey	No more information needed as completed	

Audit Topics Agreed on Forward Plan																			
Audit Title	**Priority Level**	**Speciality**	**Planned Lead**	**Audit Start date**	**Planned Completion Date**	**Quarter 1 April-June**			**Quarter 2 July- Sept**			**Quarter 3 Oct - Dec**			**Quarter 4 Jan - Mar**			**Action Plan Developed**	**Full Action Plan Implemented**
						A	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**		

Non progress of Audit – Actions Required

- Reasons to be identified by Service Audit Lead and report provided to CAG
  - Resource Implications
  - Governance Implications
  - Lack of capacity
  - Audit inappropriate to area
  - Other – to be specified
- Action plan to be agreed with timeframe for achievement and signed of by CAG, Audit Lead and Head of Service
- Failure to achieve action plan, will be escalated to Deputy Director, Workforce and Education and reported through QSG for appropriate actions.

Lincolnshire Community Health Services NHS Trust

(Title of Clinical Audit)

(Service)

Feedback Report – (Date)

Author:

Project Team:

Date report completed:

Contents **Page(s)**

All sections need completing fully

Background
(Rationale/source of the audit)

Aims & Objectives

Methodology
(Who/how/when did you audit, what did you want to achieve?)

Results – Key Findings

Conclusions & lessons learned

Recommendations

(Action plan on final page needs completing)

Follow up:

Relevant governance group(s) at which this report will be presented: *(e.g. Local Governance Group/Medicines Management/ IP&C/ Safeguarding/ Effective Practice Assurance Group)*

Date to be presented:
MM/YY

ACTION PLAN

Date completed:

Recommendation/Issue	Action	Lead Person	Timescale	Completed Yes/ No

Date(s) action plan to be reviewed:				

Minimum requirement for policy to be monitored	Process for monitoring	Responsible Individuals	Frequency of monitoring	Responsible for review of results	Responsible for development	Responsible for monitoring of HR Polices
Policy monitored through Clinical Audit Group	Monthly Audit Group	Clinical Audit Group	Monthly	Clinical Audit Group	Clinical Audit Group	Quality and Risk Group