

Clinical Audit Policy and Procedure v3.0

Key Points

- This policy applies to the management of all clinical audit activity within the Trust.
- The policy applies to all medical staff, nursing staff and allied healthcare professionals who are involved in clinical audit within the Trust.
- The Trust has a statutory responsibility to be accountable for continuously improving the quality of their services and ensuring a high standard of care as part of the governance strategy. Clinical audit forms a key element for the implementation of this framework.
- Clinical audit forms a key part of the revalidation appraisal process for medical clinicians

Key Changes

- Monitoring arrangements for this policy

Paper Copies of this Document

- If you are reading a printed copy of this document you should check the Trust's Policy website (<http://sharepoint/policies>) to ensure that you are using the most current version.

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Key Words	Clinical Audit

Revision History

Version	Status	Date	Consultee	Comments	Action from Comment
0.1	Draft	05/9	Safety & Governance Directorate	Minor changes	Minor changes made
0.2	Draft	17/9	Audit Leads through Audit Leads Away Day	Minor changes. Use of prioritisation tool.	Added prioritisation tool
1.0	Final	1/10	Clinical Standards Committee	Approved	Launched
1.1	Draft	26/10	Safety and Governance Directorate. Associate Director of Medical Safety	A number of minor changes made	Sent to audit leads for comments
1.2	Draft	9/11	Directorate Audit Leads	None received	Sent to ratification
1.3	Final	22/11	Clinical Standards Committee	Two typo adjustments	Ratified virtually
1.4	Final	20/04/11 & 7/7/2011	Clinical Standards Committee	NHSLA standard changed	Sentence added to policy to accommodate NHSLA need
2.0	Final	07.07.11	Clinical Standards Committee	Minor changes	
3.0	Final	20.11.12	Clinical Standards Committee	Minor changes	

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1. Circulation

This policy applies to anyone engaged in the clinical audit process under the auspices of Heart of England NHS Foundation Trust (HEFT). This includes:

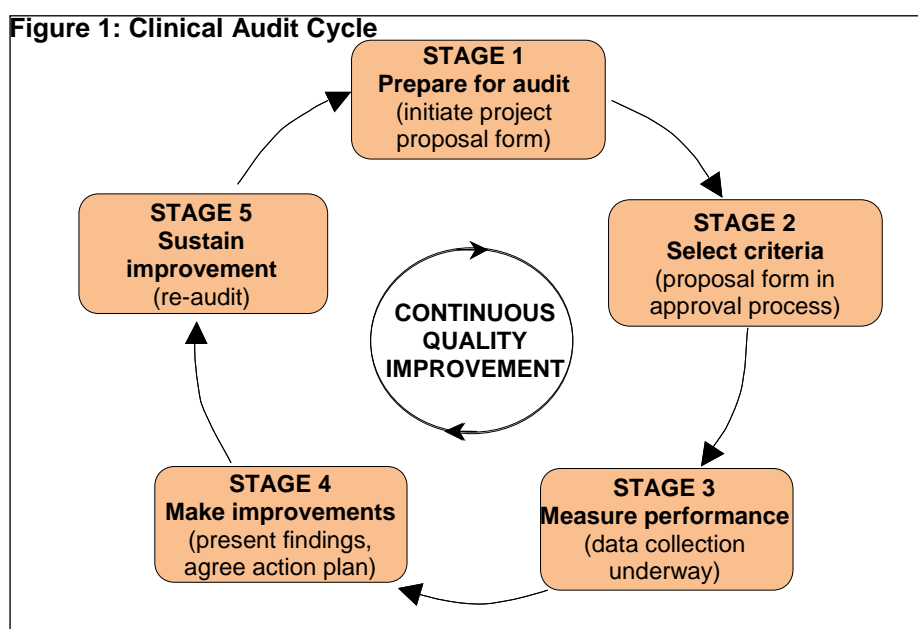
- All staff, both clinical staff (medical, nursing and allied healthcare professionals) as well as non clinical staff. The term “staff” also includes all permanent, locum, contracted and agency staff.
- Students and trainees in any discipline.

2. Scope

- **Target audience**
This policy applies to the management of all medical and nursing clinical audit activity within the Trust and excludes any non clinical/patient feedback audits.
- **Multi-disciplinary and multi-professional audit, and partnership working with other organisations**
This policy also applies to any clinical audit which is undertaken jointly across 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.

3. Definitions

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, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes. (‘New Principles for Best Practice in Clinical Audit’, HQIP 2011)



The Trust has adopted the clinical audit cycle illustrated above.

For the purpose of this policy the following definitions have also been adopted:

- **National Audit** is any clinical audit implemented on a national or regional scale that is supported by the Care Quality Commission, Royal Colleges, National

Associations, Confidential Enquiries, Strategic Health Authority or Regional Networks.

- **Guideline Audit** is a clinical audit comparing practice against NICE guidance (including clinical guidelines, technology appraisals, interventional procedures and quality standards) or evidence based local guidance.
- **Mandatory Audit** is any clinical audit (not listed above) considered essential by external assessment bodies (i.e. National Confidential Enquiries, CQC), the Strategic Health Authority, the commissioning process or to comply with Trust-wide policies (i.e. infection control, documentation audit).
- **Trust Audit** is any clinical audit (not listed above) identified by the Trust as desirable. Trust Audits can arise as a result of risk assessments, clinical incidents, complaints, claims or to deliver Trust objectives.
- **Core Audit** is any clinical audit identified by the Directorate as a priority and which will form part of the Directorate Forward Audit Plan. This may include any relevant National Audit, Guideline Audit, Mandatory Trust Audit or Trust Audit i.e. from SUI's.

4. Reason for development

The importance which the Department of Health and Healthcare Regulators attach to effective clinical audit is shown by the extent to which participation in national and local clinical audit is now a statutory and contractual requirement for healthcare providers.

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

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

The NHS Standard Contract which came into effect in April 2011 stipulates that providers must participate in the National Clinical Audit Patients Outcome Programme (NCAPOP) audits which are relevant to the services they provide, and must implement all relevant recommendations of any appropriate clinical audit, not just the NCAPOP.

In addition to this contractual requirement, the regulatory framework operated by the Care Quality Commission (CQC) and Monitor require registered healthcare providers to regularly assess and monitor the quality of the services provided. They must use the findings from clinical and other audits, including those undertaken at a national level, and national service reviews to ensure that action is taken to protect people who use services from risks associated with unsafe care, treatment and support. They must also ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of the relevant professional bodies, for example, for revalidation.

Moreover, under the Health Act 2009, the Trust is required to produce an annual Quality Account, which must include information on participation in national and local clinical audits, and the actions which have been taken as a consequence to improve the services we provide.

Therefore, this policy has been developed to provide a framework for consistent implementation and monitoring of clinical audit activity across the Trust. It outlines the Trust's commitment for ensuring that all clinicians have the opportunity, skills and support to participate in the clinical audit process and thereby continually improve their practice.

5. Aims and Objectives

The aim of this policy is to ensure that the Trust has a framework for Clinical Audit that:

- Supports the organisation in achieving continual improvement in the quality of services and provide assurance;
- Provides a focused framework on learning lessons and implementation;
- Enables compliance with statutory, national and local requirements;
- Enables clinical staff to fulfil their professional requirements to participate in the clinical audit process;
- Optimises the effective delivery of safe health care within the business resources;
- Outlines staff training requirements to ensure a skilled and knowledgeable workforce in the principles and practice of clinical audit where necessary;
- Ensures patient confidentiality and Data Protection legislation are upheld throughout the clinical audit process;
- Provides effective systems for staff to plan clinical audit projects following approval from the audit leads;
- Links into the Quality Governance Framework to provide assurance to the Trust;
- Enables multidisciplinary team-working and patient and public involvement in the audit process;

6. Policy Standards

- The Trust is committed to using clinical audit as a mechanism to understand and improve current systems, share learning and best practice and to enable demonstratable improvements in clinical outcomes, processes and the quality of patient care throughout the organisation.
- All audits undertaken should follow the process outlined within the clinical audit cycle (Figure 1) in order to provide learning and improvements locally and organisationally.
- The process to ensure the standard of audit tools used, in clinical audit across the Trust must take into consideration the following:
 - (a) Audit tools should be developed taking into consideration the NICE document "Principles for best practice in Clinical Audit 2002".
 - (b) Validated Audit tools provided by NICE, guidance standards or national audits should be used where appropriate.
 - (c) Directorate Audit leads will be responsible for approving the audit tools to be used as part of the audit approval process."
- Each audit should reflect the 'Criteria for good audit' as outlined below:
 - Should be part of a structured programme.
 - Each audit should have a local lead.
 - Service users should be part of the clinical audit process where appropriate.
 - Audits should be multidisciplinary in nature where possible.
 - Clinical audit should include assessment of process and outcome of care.
 - Standards should be derived from good quality guidelines, where applicable.
 - The sample size chosen should be adequate to produce credible results.
 - Line managers should be actively involved in audit and in particular in the development of action plans from audit enquiry.
 - Action plans should address the local barriers to change and identify those responsible for service improvement.

- Re-audit should be applied to ascertain whether improvements in care have been implemented as a result of clinical audit.
- Directorates will be asked to identify 'Core' priority audits which may include NCAPOP audits, NICE guidance, audits required as a result of Serious Untoward Incident, regulator requested audit i.e. CQC, risk register related audits and also local audits arising from a clinical need.
- All clinical audits must be registered on the Online Audit Database system following the process outlined in **Appendix 1**.
- The audit tool used will be determined by the nature of the audit being undertaken. Where possible validated and or pre set audit tools should be used. E.g. NICE Guidance tools, National Audit tools.
- All audits must be fed back to all relevant directorates, departments and staff, in the form of a report or presentation to share learning across the Trust.
- All audits should include an agreed SMART (Specific, Measurable, Attainable, Relevant and Time Bound) action plan of improvement.
- For all audits registered on the Online Audit Database, a copy of the written report or the presentation including action plan must be submitted to the Safety and Governance Directorate through the Online Audit Database system.
- The action plan must outline when and how a re-audit will be accomplished so as to evidence continual improvement where relevant. If a decision is taken not to re-audit, the reason for that decision should be documented within the audit report.
- Actions must be implemented, monitored and evidence of change provided through the Online Audit Database system.
- All audit data or presentations must be approved by the Safety and Governance Directorate and Directorate Audit Lead prior to being presented externally.

7. Responsibilities

The Trust Board, managers and staff are responsible for establishing, maintaining and supporting a coordinated approach to Clinical Audit in all areas of their responsibility. This Policy should be followed for all clinical audit activity. Some members of staff and committees have particular specialist functions in relation to clinical audit as described below.

7.1 Chief Executive

The Chief Executive retains overall responsibility to the Trust Board for overseeing an appropriate infrastructure to ensure continuous improvement in quality of care including clinical audit. He/she delegates operational responsibility to the Director of Safety and Governance.

7.2 Director of Safety and Governance

The Director of Safety and Governance is responsible for the operational management of this policy within the Trust. They will report annually to the Trust Board on all registered Clinical Audit activities.

7.3 Site / Division Medical Directors

The Site / Division Medical Directors will oversee the implementation of this policy within their respective Sites / Divisions. They will be responsible for ensuring audit arrangements are effective across their Site / Division of responsibility and lessons are learnt and implemented within their Site / Division. They will be responsible for ensuring that 6 monthly reports are provided from their directorates at the Site / Division Quality and Safety Committees in order to monitor audit progress and provide assurance to the Trust.

7.4 Clinical Directors

All Clinical Directors are responsible for overseeing a programme of clinical audit in accordance with this policy. Directorate activity will be reviewed on a 6 monthly basis at audit meetings and also through directorate reports to the Site / Division Quality and Safety Committee. Where required, the Clinical Director will nominate a Directorate Audit Lead to assist him/her with this duty.

7.5 Directorate Audit Lead

Directorate Audit Leads are responsible for local implementation of this policy and procedure within their Directorate. They will be responsible for:

- The development of local programmes of audit, including core / priority audits consisting of national audits, guideline audits, mandatory audits and Trust audits where applicable;
- Identifying directorate clinical audit training needs and signposting to resources and support;
- Promoting multidisciplinary clinical audit teams, nominating appropriate individuals to champion and lead individual projects;
- Approve directorate audit proposals and standard of audit tool.
- Consider each clinical audit proposal to ensure patient confidentiality is maintained, appropriate levels of consent are obtained, Ethics are sought where required and that the Data Protection Act is upheld prior to approval of an audit.
- Ensuring that appropriate forum(s) exists for audit planning, presentation of audit results and the development and monitoring of quality improvement projects occurring at least quarterly;
- Ensuring that audits are registered onto the Online Audit Database to enable the audit programme to be maintained:
- To review the audit programme on a 6 monthly basis with their Governance Audit Advisor
- Ensuring action plans are developed following an audit, with leads and time frames appropriately identified;
- Monitor in conjunction with the Governance Audit Advisor completion of audit actions.

7.6 Head of Clinical Governance

The Head of Clinical Governance is responsible for the implementation of this policy and procedure in conjunction with Clinical Directors and Directorate Audit leads through Site / Division based clinical governance teams and the Safety and Governance Directorate. The Safety and Governance team will:

- Horizon scan annually to identify any National Audits and National Guidance audits and inform Directorates of these documents;

- Provide training and a resource booklet to staff involved in the clinical audit processes where requested;
- Provide guidance to clinical staff on the development of Directorate Audit Forward Plan as well as audit design, report and presentation advice;
- Provide advice to Directorates in relation to the Trustwide Documentation and Consent Audit;
- Review directorate audit programmes on a 6 monthly basis with the individual Directorate Audit leads;
- Maintain and further develop the Trust Online Audit Database to enable Directorate Audit Leads to register, approve and monitor audit projects;
- Monitor, in conjunction with the Directorate Audit leads, Directorate action plans.
- Provide a Trustwide audit activity status report to the Clinical Standards Committee on a six monthly basis;
- Provide an annual report on the Trustwide Documentation and Consent audit to the Clinical Standards Committee.

7.7 All Staff

All staff across the Trust have a responsibility to ensure that they comply with this Policy, in particular:

- Seeking appropriate advice/training from the Safety and Governance Directorate;
- Seeking ethical approval for audit projects where appropriate;
- Adherence to common law on confidentiality, the Data Protection Act and any other relevant legislation.
- Fulfil any professional requirements relating to audit;

Board and Committee Responsibilities

7.8 Trust Board

The Trust Board is responsible for ensuring that the Trust has appropriate Safety and Governance systems, including clinical audit, in place to enable the organisation to deliver its objectives and statutory requirements.

7.9 Governance and Risk Committee

The Governance and Risk Committee is responsible for overseeing the Trust's Clinical Governance work programme. The Governance and Risk Committee devolve responsibility for monitoring progress with audit programmes to the Clinical Standards Committee.

7.10 Clinical Standards Committee

The Clinical Standards Committee is responsible for ensuring that Clinical Audit is integrated into the Trust's overall clinical governance work programme and that activity reflects risk management priorities as well as national priorities. This Committee is responsible for the ratification of this policy and for monitoring the implementation and its operational delivery. The Committee will review and monitor the Trust's audit activity on a six monthly basis advising the Site / Division Quality and Safety Committees of issues of concern in relation to clinical audit activity and highlighting areas of exceptional practice.

7.11 Clinical Quality Performance Group

The Clinical Quality Performance Group is responsible for ensuring that each Directorate links into the Quality Governance Framework to provide assurance to the Trust. The Group

will also monitor performance and progress with the Directorate Audit Forward Plan against established quality metrics at least bi-annually.

7.12 Site / Division Quality and Safety Committees

The Site / Division Quality and Safety Committees are responsible for ensuring that individual Directorates have in place an effective and comprehensive programme of clinical audit activity, reflecting national and local priorities, to lead to improvements in patient care and services. They will review and monitor the Site / Division's audit activity, on a 6 monthly basis. They will ensure that Directorates within their Site / Division undertake an annual program of clinical audit in accordance with this policy.

8. Training Requirements

The Safety and Governance Directorate will ensure provision of training and/or advice for all relevant clinical staff to enable them to carry out their duties and responsibilities relating to clinical audit. This will be achieved through:

- Training courses and training materials are available to individual Directorates or departments through the audit pages on the intranet or upon request;
- Follow-up/refresher training, to ensure that relevant staff maintain the appropriate level of skills to undertake/lead effective clinical audit, where requested;
- Induction training, for new staff on the clinical audit arrangements within the Trust, where requested;
- Advice service provided by the Governance and Safety Directorate offered on all aspects of the clinical audit process on request.

9. Monitoring and Compliance

Please see the table below for the method and schedule of monitoring of all clinical audits. Where deficiencies and gaps are identified through monitoring then actions will be developed and monitored by the identified committee.

Policy Objective	Monitoring / Audit Method	Frequency of monitoring	Responsibility for monitoring	Responsible Committee(s)
Each Directorate has a Forward Audit Plan of core audits, including local and national requirements	Quarterly Governance Report	Quarterly	Safety & Governance Directorate	Site / Division Quality and Safety Committee
All Core audits are conducted in line with the approved process in Section 6 and registered online	Annual Directorate Audit Programme Report	Biannually	Safety & Governance Directorate	Clinical Standards Committee
All Core audit reports are shared through a report / presentation	Annual Directorate Audit Programme Report	Biannually	Safety & Governance Directorate	Clinical Standards Committee
All Core audit findings include a methodology, conclusion in a report / presentation and action plan submitted online. Appendix 3	Annual Directorate Audit Programme Report	Biannually	Safety & Governance Directorate	Clinical Standards Committee

is an example of a template audit report.				
All Core audit projects are monitored to completion with action plans developed, evidenced and signed off to ensure improvements are made	Annual Directorate Audit Programme Report	Biannually	Safety & Governance Directorate	Clinical Standards Committee, Clinical Quality Performance Group
All Core audit projects which require a re-audit are identified online and monitored to completion	Annual Directorate Audit Programme Report	Biannually	Safety & Governance Directorate	Clinical Standards Committee

Appendix 1

Clinical Audit Procedure

The 2012/13 Trust Audit Plan has been developed in order to focus on a set of core priority audits.

Procedure Standards:

- The core priorities for audits include any relevant National Audit, Guidance Audit i.e. NICE/NICE Quality Standards, Mandatory Trust Audit i.e. Regulators requirements, Trust audits i.e. from SUI's, and Local audits targeting local areas of clinical need.
- The national priority requirement as set by NICE outlines the five main stages of the clinical audit cycle, which are:
 - Stage 1: Preparing for audit - staff begin to complete project proposal form
 - Stage 2: Selecting criteria - proposal form is going through the approval process
 - Stage 3: Measuring performance - audit work and data collection is underway
 - Stage 4: Making improvements - data collection completed, report presented, action plan agreed
 - Stage 5: Sustaining improvements - demonstrating improvements to service, through re-audit or other monitoring evidence
- Each audit should reflect the 'Criteria for good audit' as outlined in Section 6 of this Policy
- Clinical audits should be registered and monitored using the audit database process described below.

The Online Audit Registration Process v4

The audit proforma (questionnaire) must be added to the registration form before submission for approval.

To register your Audit, please follow these steps:

- 1) Log on to a Trust Networked PC using your user ID and Password (please do not attempt to do this via a generic log on).
- 2) Go to the Alphabetical Section on the homepage, A for Audit at the bottom of this list you will find a link to the Audit Database, Click the link and this will open the database
- 3) In the left hand column **Select > Create Audit.**
- 4) This will then offer you 2 options either **Existing Forward Audit** or **New Audit**
- 5) **Existing Forward Audit**
 - a) Speak to your audit lead, they have already identified some audits that will take place over the year, these are known as 'existing forward audits'. If they want you to choose one of these, simply go onto (on the left of the screen) and click on '**Create Audit**' then '**Existing**'.
 - b) You will then need to identify which directorate you are working in using the drop down boxes, your Audit lead will automatically update.
 - c) A list of all 'existing forward audits' will appear and you can choose one of them. Once you select one, you will be asked if you are sure that you want to undertake this audit, if you click 'Yes', this audit will be logged under your

username and you will now be responsible for undertaking it. **(Now move to step 6b below)**

6) **New audit**

- a) If you are proposing a completely new audit click on the '**Create Audit**' and then on '**New Audit**'.
 - b) This will bring up a new audit screen which you will have to update with the following mandatory fields -:
 - Directorate (use the drop down box)
 - Directorate Audit Lead (use the drop down box)
 - Site (use the drop down box)
 - Audit Supervisor (free text)
 - Supervisor telephone no (free text)
 - Audit Title (free text)
 - c) Then click on the '**Next**' button.
- 7) Your audit screen will update with an automatically generated audit number and further screens are now available for you to update with details of your audit most fields are of the dropdown nature where you select the appropriate response. Almost all fields are mandatory fill with the exception of the Aims and Objectives section where you just complete those that apply (at least one). The following pages must be updated before you are able to submit your audit for approval.

Click on the '**Next**' button

- a) **Project team** – You should update this section with the names of all other staff taking part in the audit.
Simply click the '**Add members**' button and input the surname or username of the person you want to add, then click '**Search**' then simply select the relevant person by clicking on '**Select user**'.
Remember to click '**Next**'.

- b) **Project Details** – All fields should be completed
 - Auditing Standard – What standard are you auditing against
 - Audit Type (use the drop down box)
 - Rationale (use the drop down box)
 - Proposed start date (use calendar)
 - Proposed presentation date (use calendar) – if not known, make a guess; this can always be amended later.
 - Aims & objectives (free text) – in this section you need to give a brief description of how the audit will either; improve patient care, improve the service, ensure against compliance or help to set local guidelines (do not answer with 'yes' or 'no')
 - Are other specialties involved – If any other directorates are taking part this must be marked YES.
 - Click on the '**Next**' button
 - Another field will appear underneath marked Affected Specialties, select '**Add members**' then update each member from other directorates individually.
 - Remember to click '**Next**'.

- c) **Methodology** – All fields should be completed

- Data collection (use the drop down box)
- Data type (use the drop down box)
- Who is going to collect the data (free text) – name of individual
- Estimated sample size (free text)
- Estimated data collection period (free text)
- Do you require an honorary contract (Yes or No)
- Do you require access to Medical Records (Yes or No) – If yes, the system will automatically contact Medical records requesting access.
- Where are the audit findings going to be presented? (Pick at least one forum, if not known pick one and update with the correct information at a later date)
- Remember to click '**Next**'.

d) Upload proforma (questionnaire)

Go to project tracker in list on LHS of page

Add proforma to Related Files

- go to browse and click on it
- Browse to where your proforma is saved
- Click on proforma
- click on open
- Click into File Description and add name
- Click on upload file

The file will upload onto the database

- e) **Audit Submission** – If all relevant fields have been updated correctly you will see 3 ✓. If there is a ✘, you will need to go to the relevant sheet and update the required information. Once all 3 ✓ can be seen you are ready to submit the audit for approval, click '**Submit Audit for Review**'.
- 8) Once you have submitted your audit the database will generate an email to the audit Lead asking him/her to approve the details, once he/she has done this you will receive an email to notify you this has been done (this will not happen straight away, how long will depend on when the audit lead is able to progress).
- 9) Once you have received your approval email you then need to go to the My Proposal Section open the audit in question and select the tracker option. This will offer you another drop down box to select the appropriate progress status.
- 10) You should also upload any relevant documents to this screen (using the related files tool), including your proforma and your audit report and or presentation before selecting Action plan identified (please discuss this stage with your Audit Lead).

Project tracker

As the audit proposer you will receive an automated email from the system 1 month after your proposed start date, and every month thereafter until you mark your audit as 'Action Plan Developed' (indicating that your audit is complete and your action plan has been developed). The tracker email will prompt you to update the 'Project Tracker'; this should be updated on a regular basis to reflect the current status of your audit.

Action plan

Once your audit has been presented, you should develop a SMART Action Plan. Once the Action Plan Identified Option has been selected and saved this will lock down the

Registration part of the database and open the Action Plan section. This needs to be discussed with your supervisor/audit lead before progressing this far.

All actions must be input into the 'Action Plan' section of the system. Simply click on 'Action Plan' on the left side of the main screen, then click on '**New Action**' this will bring up a new screen, **each action must have its own screen**, where you should input the required information -:

- Detail of action
- Lead for action
- Proposed completion date
- Evidence of action – a few words identifying what the evidence of completion will be.

To add evidence of completion to the data base

Click on Action Plan, this will bring up a list of the actions, click on add/view on the line containing the Action, the evidence can then be uploaded in the same way that files are uploaded in the Related Files part of the Project tracker.

The automated system will send an email to the lead for the action 1 month after the proposed completion date, requesting that the system be updated.

All actions should be **SMART** -:

- **Specific** - everyone who's involved knows it includes them specifically
everyone involved can understand it
your objective is free from jargon
you've defined all your terms
you've used only appropriate language
- **Measurable**- You can provide evidence that the action has been done!
You'll need a way to evaluate your progress and determine if you're moving towards your goal. For example, if you want to improve your finances, then you should have a way of keeping track of income and expenses.
- **Achievable**- Is your action achievable?
Do you have the resources in order to carry it out?
Achievable is linked to measurable...
How can I decide it's achievable:
 - you know it's measurable, others have done it successfully,
 - it's theoretically possible, you've assessed the limitations,
 - you have the necessary resources or at least a realistic chance of getting them.
- **Realistic**- Realistic is about human resources/time/money/opportunity
For example:
 - Who is going to do it?
 - Do they have (or can they get) the skills to do a good job?
 - Where's the money coming from?
 - Who carries the can?
- **Timely**- This means setting deadlines. You must include one otherwise your objective isn't measurable. But your deadlines must be realistic or the task isn't achievable.

NB When you tick the box to indicate an action is complete evidence of completion must be uploaded to the site.

For advice please contact 40325 or 42733.

Clinical Audit Report Template

SITUATION

Participants Name:

Job Title:

Specialty:

Ref No:

Audit Title:

Introduction:

- Introduction/background information on the audit topic.

BACKGROUND

Aims and objectives:

- Brief statement of what is to be achieved linked with the reason why.

Guidelines/Best Practice:

- Standards that are being audited (these should be measurable).

Methodology:

- What type of data collection was used – retrospective or prospective?
- What was the time period of the sample?
- What was the sample you selected?
- How was the data collected and by whom?
- Who analysed the data and how?

Audit Results/findings:

- Usually displayed in tables or graphs.

Conclusion/Summary:

- What were the findings of the audit?
- Did you evidence achievement of the standard being measured?

RECOMMENDATION

Recommendations:

- What should be done to improve the situation?
- Do you plan to reaudit to evidence change? If not document why not?

Action:

- Devised from recommendations detailing actions to be taken in order to achieve the recommendations (template to be found at appendix 4).

Appendix 3: Ratification Checklist

Title	Clinical Audit Policy
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	Ratification checklist	Details
1	Is this a: Combined Policy & Procedure	
2	Is this: Revised	
3*	Format matches Policies and Procedures Template (Organisation-wide)	Yes
4*	Consultation with range of internal /external groups/ individuals	Yes
5*	Equality Impact Assessment completed	.yes
6	Are there any governance or risk implications? (e.g. patient safety, clinical effectiveness, compliance with or deviation from National guidance or legislation etc)	No
7	Are there any operational implications?	No
8	Are there any educational or training implications?	<i>On-going training in place</i>
9	Are there any clinical implications?	<i>Already in place for clinicians</i>
10	Are there any nursing implications?	<i>Already in place for Nursing</i>
11	Does the document have financial implications?	No
12	Does the document have HR implications?	No

13*	Is there a launch/communication/implementation plan within the document?	Yes
14*	Is there a monitoring plan within the document?	yes
15*	Does the document have a review date in line with the Policies and Procedures Framework?	yes
16*	Is there a named Director responsible for review of the document?	<i>Yes – Chair of Clinical Standards Committee</i>

17*	Is there a named committee with clearly stated responsibility for approval monitoring and review of the document?	<i>Clinical Standards committee</i>
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Document Author / Sponsor

Signed:

Title:

Date:

Ratified by (Chair of Trust Committee or Executive Lead)

Signed

Title

Date

Appendix 4: Equality and Diversity - Policy Screening Checklist

Policy/Service Title:	Directorate:
Name of person/s auditing/developing/authoring a policy/service:	
Aims/Objectives of policy/service: to define a systematic approach and required standards for the development, ratification, implementation, monitoring, review and retirement of Policies and associated Procedures.	

<p>Policy Content:</p> <ul style="list-style-type: none"> For each of the following check the policy/service is sensitive to people of different age, ethnicity, gender, disability, religion or belief, and sexual orientation? The checklists below will help you to see any strengths and/or highlight improvements required to ensure that the policy/service is compliant with equality legislation.
--

1. Check for DIRECT discrimination against any group of SERVICE USERS:						
Question: Does your policy/service contain any statements/functions which may exclude people from using the services who otherwise meet the criteria under the grounds of:	Response		Action required		Resource implication	
	Yes	No	Yes	No	Yes	No
1.1 Age?		√				
1.2 Gender (Male, Female and Transsexual)?		√				
1.3 Disability?		√				
1.4 Race or Ethnicity?		√				
1.5 Religious, Spiritual belief (including other belief)?		√				
1.6 Sexual Orientation?		√				
1.7 Human Rights: Freedom of Information/Data Protection		√				
If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.						

2. Check for INDIRECT discrimination against any group of SERVICE USERS:						
Question: Does your policy/service contain any statements/functions which may exclude employees from operating the under the grounds of:	Response		Action required		Resource implication	
	Yes	No	Yes	No	Yes	No
2.1 Age?		√				
2.2 Gender (Male, Female and Transsexual)?		√				
2.3 Disability?		√				
2.4 Race or Ethnicity?		√				
2.5 Religious, Spiritual belief (including other belief)?		√				
2.6 Sexual Orientation?		√				

2.7	Human Rights: Freedom of Information/Data Protection		√				
If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.							
TOTAL NUMBER OF ITEMS ANSWERED 'YES' INDICATING DIRECT DISCRIMINATION =							
3. Check for DIRECT discrimination against any group relating to EMPLOYEES:							
Question: Does your policy/service contain any conditions or requirements which are applied equally to everyone, but disadvantage particular persons' because they cannot comply due to:		Response		Action required		Resource implication	
		Yes	No	Yes	No	Yes	No
3.1	Age?		√				
3.2	Gender (Male, Female and Transsexual)?		√				
3.3	Disability?		√				
3.4	Race or Ethnicity?		√				
3.5	Religious, Spiritual belief (including other belief)?		√				
3.6	Sexual Orientation?		√				
3.7	Human Rights: Freedom of Information/Data Protection		√				
If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.							
4. Check for INDIRECT discrimination against any group relating to EMPLOYEES:							
Question: Does your policy/service contain any statements which may exclude employees from operating the under the grounds of:		Response		Action required		Resource implication	
		Yes	No	Yes	No	Yes	No
4.1	Age?						
4.2	Gender (Male, Female and Transsexual)?		√				
4.3	Disability?		√				
4.4	Race or Ethnicity?		√				
4.5	Religious, Spiritual belief (including other belief)?		√				
4.6	Sexual Orientation?		√				
4.7	Human Rights: Freedom of Information/Data Protection		√				
If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.							
TOTAL NUMBER OF ITEMS ANSWERED 'YES' INDICATING INDIRECT DISCRIMINATION = 0							

Signatures of authors / auditors:

Date of signing:

Directorate:

Equality Action Plan/Report

Service/Policy:

Responsible Manager:

Name of Person Developing the Action Plan:

Consultation Group(s):

Review Date:

The above service/policy has been reviewed and the following actions identified and prioritised.
All identified actions must be completed by: _____

Action:	Lead:	Timescale:
Rewriting policies or procedures		
Stopping or introducing a new policy or service		
Improve /increased consultation		
A different approach to how that service is managed or delivered		
Increase in partnership working		
Monitoring		
Training/Awareness Raising/Learning		
Positive action		
Reviewing supplier profiles/procurement arrangements		
A rethink as to how things are publicised		
Review date of policy/service and EIA: this information will form part of the Governance Performance Reviews		
If risk identified, add to risk register. Complete an Incident Form where appropriate.		

When completed please return this action plan to the Trust Equality and Diversity Lead; Pamela Chandler or Jane Turvey. The plan will form part of the quarterly Governance Performance Reviews.

Signed by Responsible Manager:

Date:

Appendix 5: Launch and Implementation Plan

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Action	Who	When	How
Identify key users	Safety and Governance Directorate	During policy development	Through audit advisors and leads
Present Policy to key user groups	Safety and Governance directorate- Audit Advisors	Ongoing	Directorate audit meetings One to one meetings with audit personell
Add to Policies and Procedures intranet page / document management system.	Safety and Governance Directorate	Once ratified	
Offer awareness training / incorporate within existing training programmes	Safety and Governance	Ongoing	Directorate audit meetings One to one training as requested
Circulation of document(electronic)	N/A	N/A	Available on Trust Sharepoint