University Hospitals Bristol
NHS Foundation Trust

Clinical Audit Policy

Document Data			
Subject:	Clinical Audit		
Document Type:	Policy		
Document Reference:	7606		
Document Status:	Approved		
Document Owner:	Clinical Audit & Effectiveness Manager		
Executive Lead:	Medical Director		
Approval Authority:	Clinical Quality Group		
Review Cycle:	36		
Date Version Effective From:	01/03/18	**Date Version Effective To:**	28/02/21

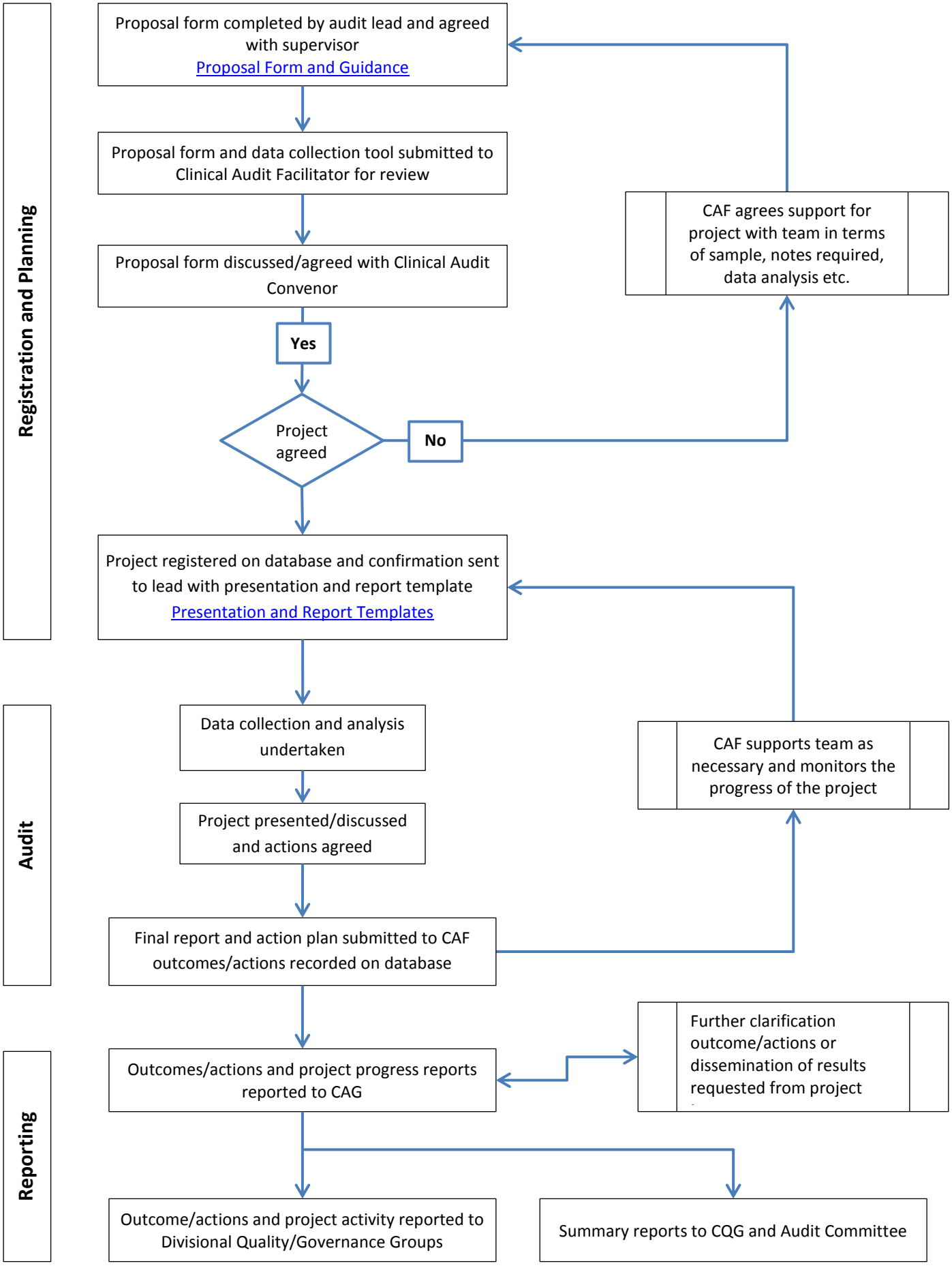
Document Abstract
The purpose of this policy is to set out a framework for the conduct of clinical audit within the Trust. It provides standards and guidance for all staff participating in clinical audit activities. It includes the Trust's procedures and expectations for registering and approving clinical audit project proposals and for developing and designing clinical audit projects.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
December 2005		Chris Swonnell	Major	Clinical Audit guidance re-issued in the form of a 'strategy' for clinical audit
November 2007	1.0 (draft)	Chris Swonnell	Major	Fundamental re-write of document to update the previous 'strategy' and incorporate a number of specific policies developed around, e.g. governance of national clinical audits; student participation in clinical audit, etc.
December 2007	1.1	Chris Swonnell	Minor	Final amendments
August 2009	2.0	Chris Swonnell	Major	Fundamental re-write of document based on a) new Trust guidance on policy development and b) guidance issued by the Healthcare Quality Improvement Partnership regarding the development of local clinical audit policies. Delayed sign-off of updated policy in light of impending release of NHSLA standard for clinical audit.
May 2010	2.1	Stuart Metcalfe	Minor	Further amendments to draft 2.0, taking into account NHSLA requirements.
September 2010	2.2	Stuart Metcalfe	Minor	Clarification of requirements in respect on national clinical audits.
March 2012	3	Stuart Metcalfe	Major	Formatting in line with new Procedural Document Framework plus other amendments in relation to NHSLA Level 3 Standards
June 2014	3.1	Stuart Metcalfe	Minor	Reference to the Francis Inquiry Report 2013 within introduction Minor amendments to terminology to reflect roles of Clinical Chairs etc. Explicate links to Board Assurance Framework or other Corporate Objectives for local audit Explicate links to agreement and monitoring of forward plan activity through Divisions Update of CAG Chair and CA Convenor role descriptions (Appendix F & G) Minor update to the content of 'Definitions of Clinical Audit, Research and Service Evaluation activity' section (Appendix E) Minor update to the Clinical Audit Code of Practice (Appendix H)
December	4	Stuart Metcalfe	Major	Review and re-write of all sections,

2017				specifically: Background linked to regulatory requirements Minor update to definition of CA in line with HQIP guidance Role of project lead/supervisor (also link to code of conduct) Policy statements created from original section Updated information governance section in light of national changes to DPA etc. Reporting outcomes/actions into divisions specified in reporting section Inclusion of process flow chart Appendices reviewed and minor amendments made. Monitoring table re-written

Table of Contents

1. Process Flow Chart



2. Introduction

2.1 University Hospitals Bristol NHS Foundation Trust (UH Bristol) is committed to using clinical audit as a mechanism for developing and maintaining high quality patient-centred care.

2.2 Clinical audit is fundamentally a quality improvement process. When carried out in accordance with best practice, clinical audit:

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

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

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

2.5 The statutory and mandatory frameworks that regulate clinical audit within the NHS in England continue to evolve. Further information is detailed within HQIP's publication, *Statutory and mandatory requirements in clinical audit*.

3. Purpose and Scope

3.1 The purpose of this policy is to set out the rationale for clinical audit and provide a framework for such activity, including standards, guidance and procedures. The policy aims to support a culture of best practice in the management and delivery of clinical audit, and to clarify the roles and responsibilities of all staff involved.

3.2 The policy applies to anyone engaged in the clinical audit process under the auspices of the Trust, e.g. students, volunteers and patients, as well as clinical staff.

4. Definitions

4.1 Clinical Audit

4.2 The Trust adheres to the definition of clinical audit set out in *Principles for Best Practice in Clinical Audit* (HQIP 2011):

"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."

4.3 The Trust supports the view that Clinical Audit is fundamentally a quality improvement process, rather than data collection *per se* (although data analysis is an essential element of the clinical audit cycle). Clinical Audit also plays an important role in providing assurances about the quality of services. However the Trust is also

clear that clinical audit is not an appropriate mechanism for investigating matters relating to the performance of individual healthcare professionals.

4.4 In the autumn of 2007, the Trust agreed working definitions of Clinical Audit, Research, Service Evaluation and Service Improvement activity, making clear the differences between these disciplines. These definitions are reproduced at Appendix A. Clinical Audit staff may occasionally facilitate non clinical audit activity, if skills and workload allow, however the Clinical Audit & Effectiveness Team's priority must, by definition, be clinical audit.

5. Duties, Roles and Responsibilities

5.1 Chief Executive

The Chief Executive is responsible for the Trust's statutory duty of quality and has overall responsibility for this policy.

5.2 Medical Director

The Medical Director is responsible for ensuring that the Trust makes adequate provision to support clinicians and managers in undertaking clinical audit.

5.3 Head of Quality (Clinical Effectiveness and Patient Involvement)

The Head of Quality is responsible for leading the development of Trust Policy and Strategy in relation to the practice of clinical audit.

5.4 Clinical Audit and Effectiveness Manager

The Clinical Audit and Effectiveness Manager is responsible for day-to-day operational matters in relation to delivery of the Clinical Audit Programme and line management of the Trust's team of Clinical Audit Facilitators.

5.5 Audit Committee

The Trust Audit Committee (a sub-committee of the Trust Board) will receive assurance relating to clinical audit activity, specifically progress against projects on the annual forward plan and the Trust's Clinical Audit Annual Report.

5.6 Clinical Audit Group

The Clinical Audit Group is the Trust's lead operational assurance group in relation to all matters relating to the practice of clinical audit. This group will be responsible for monitoring adherence to this policy. The Group will also review outcomes and actions from completed projects to ensure that results are clearly understood and that robust action plans have been produced where appropriate (including plans for re-audit). Where this is not the case, the Group will seek further clarity from project leads before accepting the project as complete. A full description of the role of the Chair of the Clinical Audit Group can be found at Appendix B

5.7 Clinical Audit Convenors

Clinical Audit Convenors are responsible for the leadership of Speciality/Division annual clinical audit programmes and the development of clinical audit within Specialties/ Divisions. A full description of the role is found at Appendix C

5.8 Clinical Audit Facilitators

The Trust will employ a team of staff to provide support and to facilitate clinical audit, however healthcare professionals are expected to undertake data collection as part of the clinical audit cycle. In this sense, Clinical Audit Facilitators are not "Clinical Auditors". Further information regarding the role of Clinical Audit Facilitators and the support provided can be found at Appendix D.

5.9 Project Leads/Supervisors

To ensure that clinical audit projects are registered and that activity is carried out in line with this policy. Specifically to ensure that projects conform to the clinical audit cycle in that the results are presented, actions agreed and implemented as necessary (and these are fed back to Clinical Audit Facilitators) and re-audit considered. Further information can be found at Appendix D.

5.10 Clinical Chairs

Responsibility for ensuring that relevant and appropriate clinical audit activity is taking place within each clinical Divisions rests ultimately with Clinical Chairs

6. Policy Statement and Provisions

6.1 Commitment to Stakeholder Engagement, Collaboration and Partnership

(a) Involving patients and the public

(i) Patients and carers may assess quality of care in different ways from healthcare professionals, each offering a unique perspective based on their personal experience. The Trust is committed to the principle of involving patients/carers in the clinical audit process either indirectly through the use of patient surveys / questionnaires or directly through participation of identified individuals on project steering groups or patient forums.

(ii) By definition, if a patient survey is being undertaken for the purposes of clinical audit, this should be in order to obtain information from service users which enables the Trust to determine whether defined clinical standards are being achieved. Other patient surveys, for example those which ask questions about patient satisfaction, will usually more appropriately be undertaken as Patient & Public Involvement activity.

(iii) All surveys involving patients of UH Bristol, other than those undertaken for the purpose of formal research, must be reviewed by the Trust's Questionnaire Interview & Survey Group (QIS) and may only be undertaken subject to receiving prior approval from the Group. A policy governing the work of the Group is available via the Trust's Connect (intranet) site.

(b) Multi-disciplinary and multi-professional audit, and partnership working with other organisations

The Trust encourages clinical audit undertaken jointly across clinical specialties, professions (including the involvement of clinical management) and organisational boundaries. Partnership working with other local and regional organisations will be encouraged where improvements to the patient journey may be identified through shared clinical audit activity.

(c) Involving Medical Students & F1/F2 doctors

(i) As a Teaching Trust, UH Bristol's policy is to actively encourage medical student involvement in its clinical audit programme where possible.

(ii) In particular, support will be extended wherever possible to Year 3 and Year 5 Medical Students who choose clinical audit for the Student Selected Component of their studies. The Trust's preferred approach is to assign Medical Students to identified projects in the agreed Trust clinical audit programme where possible. Trust guidance on student involvement, which has been agreed with the University, is provided at Appendix E.

(d) Working with commissioners

The Trust is committed to seeking the views of our local and specialist commissioners in determining its annual clinical audit priorities. The Trust will report the results and outcomes of local clinical audit activity to NHS Bristol on request. The results and outcomes of audits of NICE Technology Appraisal Guidance specifically will be reported to the local Clinical Commissioning Groups, via the BNSSG NICE College as and when requested.

6.2 Process for Setting Priorities for a Clinical Audit Programme Including Participation in National and Local Audits

(a) Process for agreeing the Clinical Audit Annual Programme.

(i) The Trust will agree an annual Clinical Audit Programme (Forward Plan), focussing on 'must do' activity. The Trust will take a consultative approach to the development of the Programme. This consultation will seek input from:

- Chairs/Operational Leads of Groups reporting directly/indirectly to CQG (via CQG)
- Divisional Directors/Clinical Chairs
- Chairs of Divisional Governance/Quality & Safety Groups (via divisional reporting)
- Health professionals working within Divisions/specialties

(ii) The Clinical Audit & Effectiveness Team will liaise with the above during the final quarter of the preceding financial year, setting a date for comments and proposals to be received by. Activity will be categorised in line with HQIP guidance.

(iii) Forward plans will be agreed and monitored through Divisional Quality/Safety Groups. Reports on progress against identified activity will be provided by the Clinical Audit & Effectiveness Team.

(iv) Progress on this activity will also be monitored by CAG and reported to CQG and to the Trust Audit Committee on a regular basis.

(b) Inclusion of national audits

(i) The Trust will seek to participate in any relevant national audits which form part of the Healthcare Quality Improvement Partnership's National Clinical Audit & Patient Outcome Programme (NCAPOP). The Trust will also seek to participate in other relevant national audits, such as those outlined within Quality Accounts, as resources permit.

(c) Inclusion of local audits

(i) In addition to participation in national audits, the Trust will develop a programme of activity which embraces:

- Clinical audit activity relating to the Board Assurance Framework or other Corporate Objectives
- Clinical audits of NICE guidance (in its various forms)

- Clinical audits resulting from gap analyses following the publication of practice recommendations from national confidential enquiries
- Clinical audits of guidance issued by patient safety or other similar bodies
- Clinical audits required to provide evidence in relation to CQUIN requirements agreed with commissioners
- Clinical audits which provide evidence to support Divisional Quality Objectives
- Clinical audits which reflect topics highlighted through incident reporting and risk registers
- Local clinical concerns/specialty priorities

(ii) The Trust is also committed to supporting clinical audits on other topics of particular interest/concern to individual clinicians. These may include audits prompted by patient safety concerns and patient feedback. In determining the choice of local projects, the Trust expects staff to take the following questions into account:

- Does the proposed audit reflect Divisional priorities (as identified in business plans, etc)?
- Can patients and other service users be involved in this project?
- Will the audit be multi-professional and encourage multi-professional working?
- Will the audit help to develop links with external partners?
- Is the audit a re-audit, thereby enabling confirmation of improvements in practice?

6.3 Governance of Clinical Audit

(a) System for registration, approval and monitoring of clinical audits

(i) All clinical audit project proposals will be formally registered with the Clinical Audit & Effectiveness Team using the appropriate forms prior to the project commencing. The latest proposal form can be found on the Trust's connect (intranet) web site here or on the Trust's external site here

(ii) Proposal forms should be approved by the relevant Clinical Audit Convenor or specialty audit lead. This should happen before the project commences. Data from the proposal form will be entered onto a central database for monitoring and reporting purposes (see 5.3(d)).

(iii) The progress of registered clinical audit projects will be monitored by the Clinical Audit & Effectiveness Team and reported to CAG at each meeting.

(iv) Where patient surveys are to be used as part of a clinical audit, these surveys must also be approved by the Trust's Questionnaire Interview & Survey (QIS) Group. The latest proposal form can be found on the Trust's connect (intranet) site and QIS Workspace here.

(b) The use of standards in clinical audit

(i) By definition, clinical audit involves measuring clinical practice against predetermined standards of best practice. The Trust expects clinical standards to be presented in a format which conforms to Principles for Best Practice in Clinical Audit (HQIP, 2011), including measurable criteria and target percentage compliance. This is reflected in the structure of the Trust's clinical audit proposal form.

(ii) Data collection tools should be submitted as part of the registration process to ensure that they reflect the standards outlined within the policy/guidance being audited.

(iii) Wherever possible, clinical audit standards should be based on robust research evidence.

(iv) Process-based clinical audit project proposals which do not make reference to standards will not be registered as clinical audit.

(c) Equality & Diversity

(i) The Trust is committed to ensuring that the manner in which project patient samples are drawn up does not inadvertently discriminate against any groups based on their race, disability, gender, age, sexual orientation, religion and belief.

(d) Information Governance: collection, storage and retention of data; confidentiality

(i) All clinical audit activity will take account of the Data Protection Act (1998), the General Data Protection Regulation (as of May 2018) and the Caldicott Principles (2013). Trust's policy is to anonymise clinical audit data unless there is a compelling reason not to do so.

(ii) Clinical audit practice must conform to the Trust's policies regarding storage of data on removable devices (e.g. memory sticks) and the secure use of email when dealing with patient identifiable information as part of a project (e.g. emailing a list of patient names/numbers for use in your sample). Further information can be found on the Trust's connect (intranet) web site here.

(iii) The Trust will provide a secure IT infrastructure to support mandatory data returns for national clinical audits. Data flows and submissions for the purposes of national, regional or multi-site audit projects will abide with Trust IG requirements for the sharing of patient identifiable data, taking into account any national guidance or requirements (e.g. the National Patient Opt-out Programme) as they develop .

(iv) The Department of Health publication Records Management: NHS Code of Practice (2006) requires "audit records" to be retained for a period of five years, although the document does not define the term "record" in this context. The Trust is currently committed to retaining clinical audit project reports indefinitely. Raw data should however be destroyed once a project has been completed, i.e. a report has been presented and the project lead is content that there is no further purpose for holding the raw data.

(v) The NHS Confidentiality Code of Practice (2003) 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" (p21). The Trust currently makes provision for this in its patient leaflet entitled 'What we do with your personal information' and therefore patient identifiable data may be collected for the purposes of clinical audit under the terms of Section 60 of the Health & Social Care Act 2001. This leaflet can be found at the following link http://nww.avon.nhs.uk/dms/download.aspx?did=1655

(vi) The Trust will maintain a central database containing details of all registered clinical audit activity. These records will be used for internal monitoring and assurance purposes, e.g. quarterly and annual programme reports. Access to the database will normally be restricted to members of the Clinical Audit & Effectiveness Team and Clinical Audit Group.

(vii) Reports written at the end of clinical audit projects should also be anonymised, i.e. not mentioning the names of patients or clinicians (for example where the relative 'performance' of different clinicians might otherwise be revealed in a report – the purpose of clinical audit being quality assurance and improvement, not performance management).

(viii) There may be occasions when the Trust engages individuals in its clinical audit activities who are not directly employed by the Trust, e.g. staff with honorary contracts, volunteers, patients and the public. Individuals who work with the Trust in these capacities will be required to sign a confidentiality agreement.

(e) Ethics and consent

By definition, clinical audit projects should not require formal approval from a Research Ethics Committee. However one of the principles underpinning clinical audit is that the process should do good and not do harm. Clinical audit must always be conducted within an ethical framework.

6.4 Reporting, Dissemination of Results and Making Improvements

(a) Presenting and reporting results

(i) Clinical audit results should be presented at Divisional/specialty audit or team meetings where the findings can be discussed, and an action plan agreed where necessary.

(ii) A formal project report should be produced for all registered clinical audit projects; this is the responsibility of the project lead. The latest report and presentation templates can be found on the Trust's connect (intranet) web site here

(b) Action plans

(i) Where the results of a clinical audit indicate the need for improvement, a SMART action plan will be produced. This will state the agreed actions, the member/s of staff responsible for delivering each action, and the target date for completion in each instance.

(ii) The project lead or supervisor is responsible for co-ordinating and overseeing the production of the action plan. If the project lead is of the view that an action plan is not required, this information is relayed to the Clinical Audit & Effectiveness Team, recorded on the clinical audit database, and open to scrutiny by Divisional and corporate committees (see 6.4(c)). The possibility of re-audit should be considered as part of this process (see 6.4(d)).

(iii) It is the responsibility of the project lead/team to produce and implement any actions identified as a result of an audit. The implementation of action plans will be monitored by the Clinical Audit & Effectiveness Team and reported to the Clinical Audit Group via a standing quarterly report. Any outstanding actions identified (those that have passed the date of completion and have yet to be implemented) will be followed up with the project team.

(c) Reporting outcomes and actions

(i) Summary reports of outcomes and actions will be reported to the Trust Clinical Audit Group at every meeting. These reports are automatically generated from project information held on the Clinical Audit Project Management Database.

(ii) Reports on clinical audit activity (including outcomes and actions) will be provided by the Clinical Audit & Effectiveness Team to Divisional Quality/Governance groups on a regular basis (currently bi-monthly).

(d) Re-audit

Re-audit is important to confirm the implementation and impact of agreed actions. The Trust's current target is for approximately 25% of clinical audit activity to be re-audited.

6.5 Training and Development

(a) Clinical Audit Training

(i) The Trust is committed to employing a team of suitably skilled clinical audit staff to support its clinical audit activity. The Trust will also ensure that these staff have access to relevant training in order to maintain and develop their knowledge and skills.

(ii) Training raises the profile of clinical audit and builds capacity and capability of all staff involved in clinical audit, so acting a driver for quality improvement. The Trust's Clinical Audit & Effectiveness Team is therefore committed to providing clinical audit training in formats which reflect clinicians' needs. This currently ranges from intensive half-day clinical audit courses to bespoke training for individual clinicians upon request.

7. Appendix A – Definitions of Clinical Audit, Research and Service Evaluation activity

	Research	Clinical Audit	Service Evaluation	Service Improvement
Definition	Aims to derive new knowledge which is potentially generalisable or transferable. Asks the question – "what is best practice?"	Aims to improve the quality of local patient care and clinical outcomes through peer-led review of practice against evidence-based standards and the implementation of change where subsequently indicated. Asks the questions – "are we following best practice?" and "what is happening to patients as a result?"	Aims to judge a service's effectiveness or efficiency through systematic assessment of its aims, objectives, activities, outputs, outcomes and costs.In different contexts, may also be referred to as "activity analysis", "benchmarking", "organisational audit", "non-clinical audit", etc. Asks questions like – "has this service been a success?" May also be used to compare the effectiveness or efficiency of a new practice/service (where supported by evidence) with an existing one - however this would be for the purposes of local comparison, i.e. not with a view to derive generalisable or transferable results (which would be research). Whilst benchmarking may be used to compare services, the evaluation will not involve measurement against agreed standards (which would be clinical audit)	Aims to improve patient care through continuous improvement of clinical outcomes and patient experience through group-led activity which focuses explicitly on quality and safety as routes to improving services, whilst also delivering essential productivity and efficiency gains. In different contexts may also be referred to as "service development". Asks questions like – "how can we make this service safer, more efficient, better for patients?"

Initiated by	Usually initiated by researchers.	Initiated by national bodies (e.g. Healthcare Commission, Royal Colleges, NICE, etc), commissioners (PCTs) or service providers (including local healthcare staff and managers)	Usually initiated by service managers/ leads.	Initiated in numerous ways: • as a corporate priority to support the delivery of the Trust's objectives • as part of a national initiative (e.g. DH, NHS Institute for Innovation & Improvement) • by individuals and/or teams in a department or speciality area • by service managers and/or clinical lead
Methodology & Design	Addresses clearly defined questions / hypotheses using systematic and rigorous processes. Designed so that it can be replicated and so that its results can be generalised to other similar groups.	Addresses clearly defined audit questions using robust methodology – usually asking whether a specific clinical standard has been met. Results are specific and local to a particular team or service although the audit tool may be used by more than one team/service	Addresses specific questions about the service concerned. Results are specific and local to a particular team or service although the evaluation tool may be used by more than one team/service.	The approach includes: • Awareness and engagement of individuals/teams so that there is agreement that improvement is necessary/possible • Analysis of the current process/ pathway highlighting areas that cause unnecessary waits and delays for patients and are wasteful of staff time • Understanding the bottlenecks, existing demand on the process and current capacity to deliver, as well as the variation that exists within the process • Designing the desired future process/pathway and agreeing the steps needed • Developing a project implementation plan that gets us to the future state • Ensuring the changes are sustained and that there is continuous improvement.
Coverage	Research projects may be service-specific, trust-wide, regional or national.	Clinical audit projects may be service-specific, trust-wide, regional or national.	Service Evaluation projects may be service-specific, or trust or community-wide.	Service improvement projects can be patient pathway specific, service/specialty specific, trust-wide, health and social care economy wide, regional or national

New treatments	May involve a completely new treatment or practice	Will never involve a completely new treatment or practice.	Will never involve a completely new treatment practice (but see Definition box above).	Will never involve a completely new treatment or practice.
Controls & Placebos	May involve use of control groups or placebo treatment for purposes of comparison	Will never involve use of control groups or placebo treatment	Will never involve use of control groups or placebo treatment	Will never involve use of control groups or placebo treatments
Patient involvement and Randomisation	May involve allocating service users randomly to different treatment groups. Patients should be involved in the design, implementation and analysis of the work.	May involve input from patients at a number of levels, e.g. • Patients may be asked to participate in surveys which help to determine whether standards have been met • Patients may be involved in the design of individual audit projects or indeed whole programmes of activity (e.g. as members of steering groups) Never involves allocating patients randomly to different treatment groups.	May involve input from patients at a number of levels, e.g. • Patients may be asked to participate in surveys which help to determine the effectiveness or efficiency of a service • Patients may be involved in the design of individual projects or indeed whole programmes of improvement activity (e.g. as members of steering groups) Never involves allocating service users randomly to different treatment groups.	May involve input from patients at a number of levels: • Patients may be asked to participate in surveys which help to determine the effectiveness or efficiency of a service • Systematic use of tools such as discovery interviews, patient diaries etc. and on-going feedback mechanism through patient involvement in redesign and service user groups • Patients may be involved in the design of individual projects to ensure the needs of different groups are met (equality and diversity issues). Never involves allocating service users randomly to different treatment groups.

Governance arrangements	Must comply with Research Governance. Must be registered with the Research and Development Department.	Must be registered with Clinical Audit Team (and therefore implicitly have been approved by the relevant Clinical Audit Convenor). Use of patient survey methodologies as part of clinical audits is also subject to approval by the Trust's Questionnaire Interview & Survey Group (QIS).	UH Bristol does not have a department of Service Evaluation; nor does it have known expertise in this field. If Service Evaluation activity is undertaken via the Clinical Audit Team or the Research & Development Department, it will be subject to the scrutiny and advice of those teams, however it should be noted that neither team currently has expertise in the field of Service Evaluation. Use of patient survey methodologies as part of service evaluations is also subject to approval by the Trust's Questionnaire Interview & Survey Group (QIS).	Delivery of the improvement programme is overseen by the Innovation Board and objectives relating to improving performance are monitored at the Trust Operational Group. Use of patient survey methodologies as part of service improvement activity is also subject to approval by the Trust's Questionnaire Interview & Survey Group (QIS).
Ethical Approval required?	Research ethics committee (REC) approval required	Should be scrutinised for ethical implications but REC approval not needed	Should be scrutinised for ethical implications but REC approval not needed	Should be scrutinised for ethical implications but REC approval not needed
End product	Generates evidence to refute, support or develop a hypothesis. May lead to development of new services or new practices.	Generates evidence to demonstrate level of compliance with agreed standards. This may lead to changes in practice.	Generates evidence of effectiveness of a service which may lead to service redesign and reconfiguration.	• Generates evidence of improvements by comparing new service performance against the baseline position at the start of the project. • Generates ideas for continuous improvement • Demonstrates skills transfer, in terms of individuals and teams understanding and applying the methodology
One-off or ongoing?	Will often be a one-off study.	May be one-off, however approximately 25% of Trust audit activity involves re-audit (seeking to confirm improvements in practice). Some audits are ongoing	Usually a one-off study, but may be repeated to compare changes over time	On-going. The approach promotes sustaining the improvements made and identifying new opportunities for improvement to develop a culture of continuous improvement

8. Appendix B – Role of Chair of Clinical Audit Group

Appointed by:	Medical Director
Reports to:	Medical Director
Key working relationships:	Clinical Audit and Effectiveness Manager Divisional/Specialty CA Convenors Divisional Clinical Chairs/Service Leads Head of Quality (Patient Experience and Clinical Effectiveness)
Term of office:	3 years (longer by agreement)

Introduction

The Clinical Audit Group is the Trust's lead Group for matters relating to the practice of clinical audit, supporting both the 'Clinical Effectiveness' and 'Patient Safety' dimensions of the NHS model of Quality. In discharging its duties, CAG will be expected to work closely with the Clinical Effectiveness Group, Patient Safety Group and the Quality Intelligence Group.

Personal Characteristics

- The Chair of Clinical Audit Group (CAG) will be a key advocate for the practice of clinical audit, and will be an important link between Executive leadership, corporate assurance and Divisional operational implementation.
- The Chair of CAG will have a clinical background at consultant level (medical or nurse/AHP) or equivalent, with knowledge and experience of using clinical audit as a methodology for both improving practice and providing assurance.
- The Chair of CAG must be an advocate/champion of multi-professional working and comfortable working with a wide range of professionals and specialities.
- The Chair of CAG should have an aptitude and interest in group management, leadership and facilitation skills and demonstrate highly developed interpersonal and team-working skills.

Key responsibilities

- To Chair meetings of the Trust's Clinical Audit Group (currently 6 meetings per year)
- To help ensure that the Trust has a clear strategy for Clinical Audit and that any objectives outlined within this Strategy are met.
- To meet regularly with the Clinical Audit & Effectiveness Manager to agree agendas, agree minutes, review actions, etc.
- To work closely with the Clinical Audit & Effectiveness Manager in providing regular reports (currently on a quarterly basis) to the Trust Audit Committee and the Clinical Quality Group (CQG), highlighting any assurance issues on behalf of the Group. The Chair will attend meetings to present these reports.
- To fulfil the role of Clinical Audit Convenor for Trust-wide projects
- To identify Clinical Audit Convenors who will lead on specific issues on behalf of the CAG (as necessary)
- To work collaboratively with the Chair of the Clinical Effectiveness Group, particular in respect of the audit of NICE guidance, and the development of systems for clinical outcomes monitoring.

9. Appendix C – Role of Divisional Clinical Audit Convenors

Last update: May 2014 (Original job description written by the Director of Human Resources in March 2001)

This is a generic outline of the role of Clinical Audit Convenor. Individual roles may differ in their detail and additional duties and responsibilities may be included by agreement.

1. Summary of Role

The Clinical Audit Convenor is responsible for the leadership of a Speciality/Division annual clinical audit programme and the development of clinical audit within the Specialty/Division.

2. Appointment

The Clinical Audit Convenor must be a healthcare professional with sufficient seniority and credibility in clinical audit activities to command the respect and confidence of staff within their Specialty/Division. The general expectation is that a Convenor serves in this role for three years, however this arrangement is flexible.

3. Accountability

Accountable to the Divisional Clinical Chair

4. Working Relationships

The Clinical Audit Convenor will work closely with clinicians, managers and clinical audit staff within their Specialty, Division and where appropriate, across Divisions.

5. Main Responsibilities

5.1 To encourage a culture of openness and participation in clinical audit across all health professions

5.2 To attend Trust Clinical Audit Group in order to:

i. Represent their Specialty/Division
ii. Enable the CAG to discharge its corporate assurance function. For example, by critically evaluating proposals and reports presented to the Group
iii. Share experiences, problems and lessons learned
iv. Actively contribute to discussions about future directions and developments in clinical audit

5.3 To liaise with other audit convenors within the Trust, particularly those within the postholder's own Division

5.4 To ensure that clinical audit is represented in Divisional governance/assurance arrangements

5.5 To provide guidance and support to Clinical Audit Facilitators and liaise regularly with them in order to:

i. Establish and maintain a structure for clinical audit within the Speciality/Division (this may include an audit committee/steering group and should include appropriate forums whereby the results of audit projects can be presented to a Speciality/Divisional audience)
ii. To identify an appropriate annual clinical audit programme within their Specialty/Division
iii. Ensure collection of information to facilitate the production of appropriate reports to the Clinical Audit Central Office and Clinical Audit Committee (i.e. enabling CAC to assure the Trust Board about clinical audit activity within the Speciality/Division)
iv. To promote patient involvement in clinical audit wherever appropriate.

10. Appendix D – Clinical Audit Code of Practice

Clinical Audit Facilitators will

- Assist clinical staff with the completion of audit paperwork
- Register the project on the trust clinical audit database
- Reach agreement with the speciality audit convenor and the audit project lead as to the level of support that the facilitator can provide to the project – the decision will take account of Divisional and Trust priorities
- This advice and support may include the following:
    a) Appropriate methodology for the proposed project
    b) Literature searching and developing measurable clinical standards
    c) Design of audit tools
    d) Choosing sample size
    e) Organising availability of clinical case-notes
    f) Extraction of data from hospital information systems (where available)
    g) Data analysis and reporting
    h) Producing presentation materials
- Monitor the progress of registered audits
- Participate in and help organise meetings within the Division to allow presentation of audit proposals and results
- Attend Divisional Governance/Quality meetings to enable the discussion and escalation of issues relating to clinical audit activity

Project leads[1] are expected to

- Ensure they are suitably conversant with the principles and practice of clinical audit and register project appropriately
- Ensure that all 'interested parties' have been consulted before the proposed project commences (data should not be gathered about clinicians' practice for clinical audit purposes without their prior knowledge)
- Ensure that due consideration has been given to the involvement of patients
- Ensure that a prior commitment is obtained from senior clinicians and management (as appropriate) that due consideration will be given to the implementation of any changes in practice indicated by the results of the audit
- Ensure that the proposed audit has clearly defined aims/objectives relating to achievable improvements in quality, and uses (or sets) explicit standards of care.
- Actively engage in all aspects of the audit cycle – including data collection – as appropriate
- Be sensitive to the possible consequences of any audit findings
- Ensure that no healthcare professional or patient can be identified directly or indirectly from a report without their explicit approval
- Present audit findings in appropriate meetings in their own speciality/division and beyond, according to the nature of the subject
- Ensure that the summary and action plan documentation is completed (this enables the Clinical Audit Group to provide necessary assurances to Trust Board about clinical audit activity)
- Ensure that an audit report is produced at the end of the project (completion of summary and action plan documentation may suffice – see audit facilitator for advice on this)
- Ensure that any external publication of audit results receives the prior approval of the speciality/division audit convenor and ethics committee approval where required

[1] The 'lead' being the clinician or manager responsible for the day-to-day management of the project

- In cases where the lead clinician leaves the Trust before the project is completed, to arrange for another clinician to take over, and to agree this with the speciality/division audit convenor

All staff actively engaged in the clinical audit process will

- Take care not to discriminate against any ethnic group, religion, sex or other social/economic group when identifying an audit population/sample
- Not knowingly engage or collude in selective methods designed to produce misleading findings
- Seek to prevent distortion or suppression of audit findings, and will not condone falsification or distortion of audit data
- Adhere to Caldicott principles and the requirements of the Data Protection Act

11. Appendix E – Statement on Medical Student involvement

Date: Last updated May 2010

University Hospitals Bristol welcomes the involvement of medical students in its clinical audit programme. In order to maximise the benefit to students and to the Trust, the following guidance is provided.

The underpinning principle of medical student participation in clinical audit at UH Bristol is that students should seek involvement in appropriate projects which are already being planned as part of Divisional clinical audit programmes. All clinical audits should be undertaken with a view to benefiting the organisation and improving patient care – audits with student involvement are no exception, i.e. these audits must do more than simply meet an academic requirement on the part of the individuals concerned. If a student comes up with their own idea for a project which meets these criteria, we will do our best to accommodate this request – however we would anticipate such audits being the exception, rather than the rule. Whilst the ideal is for students to participate in projects from beginning to end, it is possible that they may get involved in projects which have already begun, or which will not complete by the end of their involvement: they will still be able to produce a report based on their involvement and the knowledge they have acquired, even if this is not the actual project report that will be required by the Trust at the end of the project.

Clinical Audit Facilitators will:

- give students an overview of the clinical audit process
- assist with topic selection if necessary
- discuss the audit project and the relevant scope for involvement
- act as a link/liaison person throughout the project

Please note:

- although clinical audit facilitators are able to offer general advice about identifying a personal supervisor for an audit project, it is not their function to arrange links between students and specific consultants
- similarly, whilst clinical audit staff will make every effort to meet students' requests, we cannot guarantee a project being available to meet their timescales – and hence the importance of an early discussion about potential projects

Students must:

- Contact a Clinical Audit Facilitator as soon as relevant dates are known
- where there is preference for a specific specialty, contact the relevant audit facilitator (list attached)
- arrange an appointment with the Clinical Audit Facilitator in order to meet and discuss needs and timescales
- adhere to arranged appointments with both the facilitator and the project supervisor (senior clinical involved in the project) if different from the project lead.
- agree role in the project with the Personal Supervisor
- turn up for work strictly as agreed with Project Supervisor/Project Lead
- sign a confidentiality form before accessing patient information
- time and interest permitting, the student may remain in contact with the project until its conclusion

Important note: a student's Personal Supervisor may very possibly be a different person to the Project Lead. The Supervisor may not be personally connected with the audit project that the student participates in

12. Appendix F – Monitoring Table for this Policy

The following table sets out the monitoring provisions associated with this Policy.

Objective	Evidence	Method	Frequency	Responsible	Committee
5.1(a)	Involving patients and the public	Key Performance Indicator - Patient Public Involvement reported to CAG	Each meeting (b-monthly)	Clinical Audit & Effectiveness Team	Clinical Audit Group
5.1(b)	Multi-disciplinary participation in clinical audit	Key Performance Indicator - Multi-disciplinary/specialty participation reported to CAG	Each meeting (b-monthly)	Clinical Audit & Effectiveness Team	Clinical Audit Group
5.2(a)	Process for agreeing the Clinical Audit Annual Programme	Forward planning consultation process and annual clinical audit forward plan sign off by CAG	Annual	Clinical Audit & Effectiveness Team	Clinical Audit Group
5.2(b)	Inclusion of national audits	Standing report - National Audit Register	Each meeting (b-monthly)	Clinical Audit & Effectiveness Team	Clinical Audit Group
5.3(a)	System for registration, approval and monitoring of clinical audits	Key Performance Indicator - project registered/approved before start reviewed by CAG Standing report - project progress report reviewed by CAG	Each meeting (b-monthly)	Clinical Audit & Effectiveness Team	Clinical Audit Group
5.3(b)	The use of standards in clinical audit	Standing report - Outcomes against standards reported to CAG	Each meeting (b-monthly)	Clinical Audit & Effectiveness Team	Clinical Audit Group
5.3(d)	Information Governance: collection, storage and retention of data; confidentiality	Standing report - Project progress report reviewed by CAG	Each meeting (b-monthly)	Clinical Audit & Effectiveness Team	Clinical Audit Group
5.4(a)	Presenting and reporting results	Standing report - Outcomes and actions reports reviewed by CAG Key Performance Indicator - report produced reviewed by CAG	Each meeting (b-monthly)	Clinical Audit & Effectiveness Team	Clinical Audit Group

Objective	Evidence	Method	Frequency	Responsible	Committee
5.4(b)	Action plans	Standing report - Outcomes and actions reports reviewed by CAG. Key Performance Indicator - action plan produced	Each meeting (b-monthly)	Clinical Audit & Effectiveness Team	Clinical Audit Group
5.4(c)	Action plans	Standing report - Outcomes and actions reports reviewed by CAG. Outcomes and actions reported to Divisional Governance Quality Groups	Each meeting (b-monthly)	Clinical Audit & Effectiveness Team	Clinical Audit Group
5.5(a)	Clinical Audit Training	Training summary report reported to CAG Review of feedback forms	Annual	Clinical Audit & Effectiveness Team	Clinical Audit Group

13. Appendix G – Dissemination, Implementation and Training Plan

13.1 The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Clinical Audit & Effectiveness Manager
This document replaces existing documentation:	Yes
Existing documentation will be replace by:	Existing Clinical Audit Policy
This document is to be disseminated to:	[DITP - Document to be disseminated to]
Training is required:	No
The Training Lead is:	N/A

Additional Comments
[DITP - Additional Comments]