In partnership with

Good Governance Institute

HQIP
Healthcare Quality Improvement Partnership

Clinical audit:
a guide for NHS boards and partners
Summary

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Contents

HQIP Healthcare Quality Improvement Partnership

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Clinical audit: a guide for NHS boards and partners

What is this guide and who is it for?

This new guide has been redrafted to reflect the changes in architecture in the NHS in England, the Health and Social Care Bill, the lessons from Mid Staffordshire and Keogh Reviews and the enhanced focus on well led organisations. The guide is focused on the developing role of quality improvement, audit and review in providing assurance by clinicians to boards, stakeholders and commissioners that services are well led, delivering responsive improved cost effective outcomes with transparency in choice of audit, action plans and impact. It provides guidance to those commissioning, delivering and scrutinising the added value of clinical audit and other assurance systems.

Clinical audit is just one tool of the wider quality improvement (QI) strategy aimed at providing assurance of delivery to best practice. Any problem should be identified within the broader quality improvement framework, which then determines whether clinical audit might provide the best methodology to achieve the desired outcomes with the available expertise on the ground. There is a need for national standardisation and professionalisation of quality improvement for clinical audit and beyond with better QI governance structures. Effective clinical audit should be standard practice and should provide clear guidance on where, how, and when to use resources effectively. Clinical audit should also extend beyond strict organisational boundaries following the pathway of care, and constitute an outcome-focused process that is transparent, explaining the decision to use clinical audit, action plans and impact.

The guide identifies 10 simple rules and goes on to develop each of these, highlighting the importance of linking actions between the board, divisions and departments and how to implement improvements. Each rule has a simple Q&A section presenting at board, division and departmental level a common but unacceptable response and a more mature response. At the end of the document are sets of these Q&As for use at the various levels, as well as a maturity matrix to provide an overall perspective on how well we are doing now and what needs to be achieved in coming months.

The guide is accompanied by the new Good governance handbook[1] , which is focused on assisting NHS boards and those developing governance systems to decide what is most appropriate for the specific needs of their organisation. Emphasising the developing role of clinicians in management and resource allocation, the Good governance handbook aims to help existing and aspirational clinical, nurse and medical directors as well as those who support and challenge them to understand and apply good governance in the rapidly changing environment of the NHS in England.

1. Corbett-Nolan, A. et al., 2014, *Good governance handbook*

Clinical audit: 10 simple rules for NHS boards

1. Use clinical audit as a tool in strategic management as part of the broader quality improvement programme; obtain assurance that the strategy for clinical audit is aligned to broader interests and targets that the board needs to address
2. Consider the full range of quality improvement tools and choose clinical audit if its methodology is best suited to assess the issue at hand and develop an improvement plan
3. A clinical audit strategy must include a combination of national and local priorities with sufficient resources to complete the cycle for each element of the programme
4. Agree on the timescale and resources required for each clinical audit activity upfront but have a process in place to deal with variations and additional requirements
5. Operate a rolling clinical audit programme that covers the different stages of individual projects on a continuous basis focused on outcome improvements for each area
6. Ensure the professionalism of clinical audit by agreeing what constitutes unacceptable variation in clinical audit results compared to evidence based standards, outcomes at similar organisations, or with standards developed within the organisation where national guidelines are not available
7. Ensure with others that clinical audit crosses care boundaries and encompasses the whole patient pathway
8. Develop a clear strategy to ensure patient and stakeholder engagement at the different stages of the clinical audit cycle, make clinical audit reports patient-friendly and publicly available, and disseminate summaries of results to stakeholders and patients in a variety of ways
9. Share clinical audit results with other providers, commissioners, regional clinical networks and local patient networks. Publish outcome statistics and evaluations
10. Provide sufficient education and training in clinical audit beyond the clinical audit team, and use junior doctor clinical audit and quality improvement projects as a valuable resource

Clinical audit as part of the modern healthcare system

Participation in national clinical audits and publication of outcome statistics is now required as part of the NHS England Standard Contract and CQC guidance. We have seen a considerable expansion and enhancement of the portfolio of national clinical audits in recent years posing new capability challenges, as demand by clinicians, boards and commissioners is increasing.

Stakeholder engagement in clinical audit processes and the involvement of Healthwatch in particular, should now be a standard part of every clinical audit programme.

Information governance guidelines and requirements have changed significantly with NHS England monitoring the digitalisation process of each provider and the Health and Social Care Information Centre increasingly publishing outcomes data through care.data. Monitor's new Risk Assessment Framework[2] constitutes a useful guide for providers and commissioners. The value of accreditation as external assurance and assessment of the independence of internal audit is becoming more significant and can raise the profile of the organisation.

2. Monitor, 2014, *Risk Assessment Framework*

Assurance questions, with possible answers
Board level

	Question	Unacceptable answer	Acceptable answer
1	**Is our clinical audit strategy aligned to the organisation's broader strategic interests and used as assurance in our board assurance framework?**	Clinical audit is planned and conducted by our clinical audit team, which reports back to the board. Clinical audits may provide assurance where they coincide with strategic priorities	We ensure that our clinical audit programme is aligned to the broader strategic interests of the organisation and other aspects of our strategic management. We have identified where clinical audit can provide assurance to commissioners and us, gaps are addressed in forthcoming plans and budgets. The board shapes the clinical audit strategy to address wider strategic priorities
2	**Has clinical audit been selected as the methodologically most suitable tool for the issue at hand?**	Clinical audit is our standard quality improvement tool	Yes, within our broader quality improvement strategy, we have a robust process for ensuring that each quality improvement method is chosen for its merit and impact. Clinical audit is utilised when it has been identified as the most effective tool to improve and assure the quality of the service delivered
3	**Do we have a clinical audit strategy with a balanced combination of national and local priorities?**	We have an existing clinical audit plan, mostly focused on national clinical audits, which often does not leave resources for additional local audits	Balancing the national and local components of our clinical audit programme, the board shapes the audit strategy to address wider priorities with sufficient funds and resources earmarked for relevant local audit activity and follow up
4	**Are our clinical audit cycles comprehensive, timely and outcome-focused?**	Our annual clinical audit cycle is usually larger than resources permit and inevitably creates a backlog	Yes, the purpose of clinical audit is improvement. We operate a trust-wide rolling audit programme, which covers all stages of the audit cycle, but allows prioritisation and stakeholder involvement in-year. We do not consider audits complete until we have re-audited and reported improvement
5	**What proportions of approved clinical audits have been completed to time and budget?**	The time and budget allocated for clinical audit is sometimes not sufficient to cover the whole clinical audit cycle and does not leave resources for additional pathway and re-audits	We are assured by a delegated sub-committee of the board that x% of re-audits are completed. Where there is a lack of assurance the appropriate committee identifies and reviews action plans. Clinical audits that are health economy wide or have a strategic impact on clinical services are presented to the board

	Question	Unacceptable answer	Acceptable answer
6	**Has the board agreed what constitutes materiality, unacceptable variation in clinical audit results against standards and comparisons with others?**	Clinical audit has guidelines but no system of accreditation so we are left to ourselves in determining whether we consistently follow best practice	We have adopted a professional approach to clinical audit, setting auditable procedures for selecting and delivering audit-based improvement in any area. This allows the board to determine materiality (risk, value and return) and trigger points for escalation to the board as well as benchmarking to compare with norms and emerging better practice
7	**Do we engage with other organisations during the clinical audit process?**	We are not accountable once the patient has left the care of our organisation. Individual clinicians may engage with colleagues in other departments or providers where necessary	Our quality improvement programme is focused on the patient pathway, and working in partnership with other health and social care providers and commissioners involved in these pathways, has proven to improve overall care in our community. We invite external organisations to peer- review our approach
8	**Are patients and stakeholders engaged in the clinical audit process?**	The results of our clinical audits are publicly available and we disseminate a summary of them to commissioners and stakeholders	To ensure Patient and public involvement (PPI), we involve patient and stakeholder representatives in our clinical audit programme development, individual projects and as part of the decision making process through the governance structure. Our clinical audit reports have become more patient-friendly and a summary of the processes and improvements resulting from audits is shared with stakeholders and patients in public meetings and in our newsletter
9	**Do we share our clinical audit results with other providers and commissioners, and publish our audit outcome statistics and evaluations?**	We publish the outcome statistics of national clinical audits, but share outcomes of local clinical audits only with partner organisations or commissioners	We share our results with local partners (providers/commissioners) and with our regional clinical and patient networks. We are working with our commissioners and others in planning whole system audits. Outcome statistics of our performance in national clinical audits are published online, with commentaries to make them easily accessible and understandable
10	**Do we provide sufficient education and training in clinical audit, and use junior doctor quality improvement projects effectively?**	Budgets have been cut so training is now limited to mandatory requirements. We rely on the medical schools to provide appropriate training	Clinical audit is recognised as an important feature of our induction and further training programmes on clinical governance and quality. We have developed a cost improvement regime which allows divisions to retain a proportion of savings for training and improvement activities

Assurance questions, with possible answers
Division level

	Question	Unacceptable answer	Acceptable answer
1	**Is our clinical audit strategy aligned to the organisation's broader strategic interests and used as assurance in our board assurance framework?**	We have a backlog of audits which we are tackling	The board has identified major concerns where performance or assurance is lacking and prioritises these. We respond with a plan or raise resourcing issues. Ad hoc urgent requests are responded to within the same year
2	**Has clinical audit been selected as the methodologically most suitable tool for the issue at hand?**	Staff tend to use the approach they are comfortable with	We have trained staff in a wide range of improvement tools and we routinely review the best approach for the issue. We aim to learn from mistakes and improve best fit approach
3	**Do we have a clinical audit strategy which balances a combination of national and local priorities?**	Clinicians are aware of their responsibilities to be involved when other priorities permit	We identify a rolling programme of clinical priorities for audit and ensure that all clinicians across the local health and care economy are involved in clinical audit and other improvement programmes as part of their training and revalidation
4	**Are our clinical audit cycles comprehensive, timely and outcome-focused?**	We have a wish list of topics but rarely cover them all. New audits are getting in the way of re-auditing old ones	We have a plan with a clearly defined timeline for specific measures and actions, and clearly defined roles of team members responsible for their implementation. The action plan recognises and addresses the reasons for shortfalls in the quality of care
5	**What proportion of approved clinical audits has been completed to time and budget?**	We do not have a budget but undertake a considerable range of audits each year	Clinical audits are logged with the clinical audit lead, resources and timescales are prioritised. Variations and requests for pathway audits are logged and reported to the lead clinician. The division tracks the delivery of audits across all of its specialities/departments

	Question	Unacceptable answer	Acceptable answer
6	**Has the board agreed what constitutes materiality, unacceptable variation in clinical audit results against standards and comparisons with others?**	NICE[3] and others provide some condition based standards but we do not have identified trigger points for early escalation of unacceptable variation. The lack of national standards prevents us from implementing audits of some areas of concern	We follow our agreed professional standards in conducting audit, working where possible with other organisations to gauge acceptable and improved practice and outcomes. Trigger points for prompt escalation of unacceptable variation are being worked on for each condition
7	**Do we engage with other organisations during the clinical audit process?**	Our audit programme is insufficiently aligned to involve more than one department. We would not know what other organisations are doing to conduct joint audits	We have a good relationship with our commissioners and both specialist and local providers to allow us to extend our audits along patient pathways. We have learnt and seen improvement using this approach
8	**Are patients and stakeholders engaged in the clinical audit process?**	We receive family and friend and complaint summaries but these are not used to influence audits	We routinely receive quality alerts generated by referring GPs. Our complaints systems seek to reflect these in selecting and designing audits and other improvement approaches
9	**Do we share our clinical audit results with other providers and commissioners, and publish our audit outcome statistics and evaluations?**	Unfortunately we are unable to provide outcomes other than anonymised summaries for discussion	We have developed protocols for sharing confidential information across health and social care and are now able to facilitate detailed discussions on improvements identified in both national and local audits
10	**Do we provide sufficient education and training in clinical audit, and use junior doctor quality improvement projects effectively?**	We have trained clinical audit facilitators and others in the quality improvement team. Junior doctor clinical audit quality improvement projects involve a training exercise yet to be completed	We have regular clinical audit workshops and invite our staff to participate in further speciality specific external training and networking. Junior doctor clinical audit and quality improvement projects are a valuable quality improvement resource, and focus on issues that have been identified as benefiting from examination

3. National Institute for Health and Care Excellence – www.nice.org.uk

Assurance questions, with possible answers

Department level

	Question	Unacceptable answer	Acceptable answer
1	**Is our clinical audit strategy aligned to the organisation's broader strategic interests and used as assurance in our board assurance framework?**	No, probably not	We aim to balance departmental needs with strategic and national requirements, escalating any resourcing or traction issues
2	**Has clinical audit been selected as the methodologically most suitable tool for the issue at hand?**	We are used to clinical audit and this is the approach we normally use	We have adopted a best-fit guide to check we are using the best approach for each quality issue
3	**Do we have a clinical audit strategy that balances a combination of national and local priorities?**	We simply do not have the time to engage other than in mandatory national audits	We have a listing of planned and completed local audits for each trainee and ensure that all clinicians meet their training and revalidation requirements in a timely fashion
4	**Are our clinical audit cycles comprehensive, timely and outcome-focused?**	We are getting overwhelmed with requests for new audits and frankly have to ignore them	We complete what we start and raise exception notes for delays and unfinished audits. Identified variation is never left unattended to
5	**What proportion of approved clinical audits has been completed to time and budget?**	Consultants decide what audits are completed	The department tracks the delivery of its agreed clinical audit programme and escalates issues and concerns to the divisions

	Question	Unacceptable answer	Acceptable answer
6	**Has the board agreed what constitutes materiality, unacceptable variation in clinical audit results against standards and comparisons with others?**	We follow national guidelines on conducting audit but have not reviewed compliance	We follow our agreed professional standards in conducting audit which has allowed us to review and improve compliance
7	**Do we engage with other organisations during the clinical audit process?**	No	In developing audits we always work hard to ensure at least the interface with other departments or even external organisations is covered
8	**Are patients and stakeholders engaged in the clinical audit process?**	No	We have systematic feedback from service users and these are used in both selecting and designing audits. We inform users of changes made from their suggestions
9	**Do we share our clinical audit results with other providers and commissioners, and publish our audit outcome statistics and evaluations?**	Detailed results are confidential	The local protocols have allowed much greater discussion on whole system improvements and facilitated cross boundary work
10	**Do we provide sufficient education and training in clinical audit, and use junior doctor quality improvement projects effectively?**	No, budgets have been cut so training is now very ad hoc and limited to mandatory requirements	The junior doctor quality improvement projects approach has had a significant impact in providing focus for listening and improving services

This guide and further information is available at: www.hqip.org.uk and www.good-governance.org.uk
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