CLINICAL AUDIT POLICY

Document Author	Authorised Signature
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6 Dec 12	3.2			Minor amendments	Ratified at Quality and Patient Safety Committee
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17 Jan 12	4	17 Dec 15	Executive Director of Nursing		Approved at Executive Board
1 Sep 14	4.1		Executive Director of Nursing & Workforce	Changed to reflect change in process, and committee structure.	
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12 Dec 18	6.0		Medical Director	Approved at	Policy Management Sub -Committee

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust.

Contents **Page**

1. Executive Summary:

The purpose of this policy is to set out a framework for the conduct of clinical audit within the Trust. It provides standards and sets out the process for all staff participating in clinical audit activities. It includes the Trust's procedures and expectations:

- for registering and approving clinical audit project proposals;
- for developing and designing clinical audit projects;
- for reporting and presenting audit findings

setting out the support that is available from the Clinical Effectiveness Team. All clinical audit activity undertaken in the Trust must comply with the requirements of this policy.

The Trust has adopted the following definition of 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.

(HQIP 'New Principles for Best Practice in Clinical Audit'*. Radcliffe Publishing, 2011)*

2. Introduction

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 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.

The NHS standard contracts for acute hospital, mental health, community and ambulance services which came into effect in April 2011 cover agreements between commissioners and all providers delivering NHS funded services. The contract terms apply to new agreements from April 2011 for NHS Trusts including services provided by Isle of Wight NHS Trust. Providers must participate in the National Clinical Audit Patients Outcome Programme audits which are relevant to the services they provide and must implement all relevant recommendations of any appropriate clinical audit, and those required as part of the Quality Account (HQIP).

In addition to this contractual requirement, the regulatory framework operated by the Care Quality Commission (CQC) requires 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).

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

2.1 The National Clinical Audit and Patient Outcomes Programme (NCAPOP)

NCAPOP audits are commissioned and managed on behalf of NHS England by the Healthcare Quality Improvement Partnership (HQIP). This programme comprises of more than 30 national audits related to some of the most commonly-occurring conditions. On a local level, NCAPOP audits provide the Trust with individual benchmarked reports on their compliance and performance.

As well as the 30-plus national clinical audits, NCAPOP also encompasses the four Clinical Outcome Review Programmes (CORP), which help to assess the quality of healthcare and stimulate improvement by enabling clinicians, managers and policy makers to learn from adverse events and other relevant data.

The Contract between the NHS Isle of Wight Clinical Commissioning Group and the Isle of Wight NHS Trust requires that the Trust contributes to relevant national audits and studies and report this as part of the Trusts Annual Quality Account.

3. Definitions

A list of definitions is provided within the appendix (Appendix A).

4. Scope

This policy is applicable to all staff employed or undertaking audit under the auspices of the Isle of Wight NHS Trust, including students, volunteers and patients, as well as staff.

4.1 Multi-disciplinary and multi-professional audit, and partnership working with other organisations

The Trust encourages clinical audit undertaken jointly across professions and 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

4.2 Involving patients and the public

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

5. Purpose

The purpose of this policy is to set out a framework for conducting 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;
- for developing and designing clinical audit projects;
- completing the audit cycle through action plans;

and sets out the support that is available from the Clinical Effectiveness Team. All clinical audit activity undertaken in the Trust **must** comply with the requirements of this policy.

6. Roles and responsibilities

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

6.2 The **Medical Director** is the executive lead for clinical audit as part of the quality agenda and has the responsibility:

- To ensure that the Trust clinical audit annual programme of work are aligned to the Boards strategic interests and concerns
- To ensure that clinical audit is used appropriately to support the Board Assurance Framework
- To ensure this policy is implemented across all clinical areas
- To ensure that any serious concerns regarding the Trust's policy and practice in clinical audit, or regarding the results and outcomes of clinical audits, are brought to the attention of either or both of the Quality Committee and the Audit Committee whichever is the more appropriate escalation.

6.3 The **Clinical Effectiveness Lead (CEL)** is responsible for:

- Ensuring that an annual audit programme is developed which reflects national and Trust priorities, and is delivered in line with agreed audit procedures
- Ensuring that the Trust is notified of new initiatives that impact on clinical audit.
- Ensuring that clinical audit training is available to all staff undertaking clinical audit, either through e-learning or face to face packages.
- Provision of a quarterly report to the Acute Division Quality Meeting with reports by exception in the intervening months
- Ensuring that reports are sent to Care Group Quality Risk and Safety Meetings on a monthly basis that identifies current status with audit activity
- Ensuring that lessons are learnt from clinical audit and action plans are developed and completed and re-audit occurs where appropriate.
- Ensuring that an annual audit report is produced.
- Is responsible for ensuring the policy is reviewed on a 3 yearly basis or earlier, in line with the national directives

6.4 The **Clinical Effectiveness sub-Committee (CEsC)** is the Board Assurance Committee tasked with overseeing the Trust's clinical audit activity and is responsible for monitoring delivery of the annual audit programme both on commencement and completion. The committee also has a duty to ensure that any areas of poor practice are identified to the most appropriate forum, and that they seek assurance that issues have been rectified.

6.5 The **Quality Advisors** are responsible for supporting the CEL and Care Groups with the development, monitoring and delivery of the annual clinical audit programme using agreed audit processes.

6.6 The **Care Groups** are responsible for ensuring that a programme of clinical audit is undertaken on a continuous basis, which is linked to national and local priorities. The Care Groups must also ensure that any recommendations following clinical audit outcomes are taken forward and issues addressed, including placing entries on the risk register should any significant concerns be identified during the review of clinical audit outcomes. All clinical audits are to be reviewed by the relevant Care Group prior to registration and inclusion in the Clinical Audit Programme and reviewed at the conclusion of the audit.

6.7 **Care Group Directors / Heads of Nursing and Quality** have a responsibility to oversee the clinical audit programme for the Care Groups via their Quality, Risk and Patient Safety meetings and link closely with the Quality Advisors to support the facilitation of clinical audit activity across the Care Group.

6.8 **Care Group Quality Managers** are responsible for:

- Ensuring that this policy is implemented throughout their Care Group.
- Ensure that all clinical audits to be undertaken are included in their Care Group Quality Meeting before registration on the Trust Clinical Audit Programme
- Ensuring that all clinical audit activity is registered and complies with nationally accepted best practice standards
- Ensuring that all completed audits are presented at the conclusion of the audit
- Ensuring that there is participation in all relevant national clinical audits, national confidential enquiries and and service reviews which are relevant to the services which it provides
- Working with clinicians, service managers, and the Clinical Effectiveness Team to ensure that the clinical audit programme meets all clinical, statutory, regulatory, commissioning and other Trust requirements.

6.9 **Service Managers** are responsible for ensuring that service development and delivery is underpinned by clinical audit and forms part of Continuing Professional Development for staff.

6.10 **All professional staff** are individually accountable for ensuring that they audit their own practice as defined by their codes of practice using the agreed Trust audit processes.

6.11 **All medical staff** have a responsibility to undertake clinical audit as part of their continuing professional development, and as such should follow the agreed audit processes. Clinical Audit is a requirement for revalidation of Consultants and Specialty Doctors. Medical staff also have a duty to ensure that the results of any audits are fed back at the relevant Care Group's Quality, Risk and Patient Safety meeting.

6.12 The **Director of Medical Education (DME) and Medical Education Manager (MEM)** share the responsibility to ensure doctors in training are aware of the audit process towards LEP's/GMC requirements. The DME oversees the annual Clinical Audit Prize.

6.13 **Clinical Audit Sponsors** (please see Key Definitions, Appendix A) have a duty to support audit leads to undertake clinical audit using agreed Trust processes; **this includes ensuring that a relevant topic is chosen from a** list of re-audits or an audit of NICE guidance where a significant level of compliance has been declared. Clinical Audit Sponsors are also responsible for ensuring that the clinical audit is taken through the complete audit cycle.

6.14 **All Staff** undertaking clinical audit activity must be aware of and adhere to procedures for clinical audit as defined in this policy and ensure that they comply with relevant legislation and guidance regarding the use of data handling / processing including the General Data Protection Regulations 2018, Data Protection Act 2018, Freedom of Information Act 2000 and the Caldicott Principles.

6.15 The **Clinical Effectiveness sub-Committee (CEsC)** responsibilities are:

- To review the current audit programme and provide advice and guidance on taking this forward
- To receive clinical audit presentations once audits have been completed
- To champion clinical audit within the organisation and encourage participation
- To meet quarterly to review progress and offer direction
- To communicate effectively on a regular basis
- To assist in unblocking issues that could delay progress
- To regularly report progress to the Quality and Audit committees

7. Policy detail / course of action

7.1 Improvement and assurance

The Trust supports the view that whilst Clinical Audit is fundamentally a quality improvement process, it also plays an important role in providing assurances about the quality of services.

The Trust considers that the prime responsibility for auditing clinical care lies with the clinicians who provide that care. The Trust is committed to supporting clinicians who carry out clinical audit by providing advice and assistance from appropriately trained and experienced staff, and advice and training in clinical audit processes and practice. Appropriate advice and training will also be made available to non-clinical staff and patients who may be involved in clinical audit projects.

In addition, the Trust is committed to ensuring that:

- It participates in all national clinical audits, national confidential enquiries and inquiries and service reviews which are relevant to the services which it provides
- All clinical audit activity within the trust, or conducted in partnership with external bodies, is registered and conforms to nationally agreed best practice standards (See HQIP Criteria and indicators of best practice in clinical audit January 2012)

- The annual programme of clinical audit activity meets the requirements of the Board Assurance Framework, and includes all of the clinical audits necessary to meet regulatory and commissioner requirements
- It meets any audit needs identified through the risk assessment process
- Adequate records of the clinical audit annual programme, individual clinical audit projects and reviews of the results of national clinical audits, national confidential enquiries and inquiries and service reviews are maintained in order to demonstrate compliance with regulatory and other requirements.

7.2 Choosing topics and planning projects

7.2.1 Agreeing an annual programme of activity

Prior to the start of every financial year, the Trust will agree an appropriate planned programme of clinical audit activity. This programme should meet the Trust's corporate requirements for assurance, and be flexible to meet identified needs; but must be owned by clinical services.

The Trust is committed to supporting other locally determined clinical audit activity as a significant contributor to the continuous process of service improvement. It is acknowledged that individual clinicians may initiate a clinical audit project on the basis of personal interest, personal development or as part of an educational or training programme. It is essential that these are registered with the Trust and reported through existing clinical governance structures to maximise organisational learning.

The annual programme will be reviewed by CEsC at the beginning of each financial year.

7.2.2 Choosing and prioritising local clinical audit topics

The local clinical audit topics will be determined by the Care Groups, the following should be used to determine the priority areas:

- Aggregation of data from risks/incidents, complaints/concerns, patient feedback and claims.
- National guidance issued by National Institute for Health and Care Excellence (NICE) or Royal Colleges
- National Patient Safety Alerts
- Risks and priorities
- New Procedures / Expanded /Advanced Practice
- New policies as and when required
- Service Redesign

In setting priorities consideration should be given to the added value audit can achieve as evidence against contractual requirements. Contracts include many levers to improve quality and providers will be challenged more and more around achievement of these quality measures, which may have significant financial consequences for a provider.

7.2.3 Systems for registering and approving audits

All clinical audit activity must be registered with the Clinical Effectiveness Team irrespective of the level of facilitation being requested of the Department.

All clinical audit activity must have been fully endorsed by the Care Group prior to submission for inclusion on the programme – using the registration document. This can be found at: http://intranet/index.asp?record=107 All local audit proposals must be presented at the Care Groups Quality Risk and Patient Safety Meetings for discussion and approval before being submitted to the Clinical Effectiveness Team for registration and inclusion in the Trust Clinical Audit Programme.

7.2.4 Use of audit databases

Data provided on registration will be used to compile a database of all clinical audit activity undertaken throughout the Trust. This database will be updated regularly by the Quality Advisors and will be used to report to the Clinical Effectiveness sub- Committee on the progress of the annual clinical audit programme.

7.2.5 The use of standards in clinical audit

By definition, clinical audit involves measuring clinical practice against predetermined standards of good practice. The Trust expects all registered clinical audit projects to have clearly defined audit standards. All audits should adhere to best practice standards as defined in publications such as 'New Principles for Best Practice in Clinical Audit' January 2011.

Any project proposals which do not involve clear measurable standards will not be registered or managed as clinical audit.

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

All clinical audit activity must comply with the standards of the General Data Protection Regulations (GDPR) and the Data Protection Act 2018 (DPA 2018) are based on the six DPA 2018 principles

- The first data protection principle is that the processing of personal data for any of the law enforcement purposes must be lawful and fair

- The second data protection principle is that—

(a) the law enforcement purpose for which personal data is collected on any occasion must be specified, explicit and legitimate, and

(b) personal data so collected must not be processed in a manner that is incompatible with the purpose for which it was collected.

- The third data protection principle is that personal data processed for any of the law enforcement purposes must be adequate, relevant and not excessive in relation to the purpose for which it is processed.

- The fourth data protection principle is that—

(a) personal data processed for any of the law enforcement purposes must be accurate and, where necessary, kept up to date, and

(b) every reasonable step must be taken to ensure that personal data that is inaccurate, having regard to the law enforcement purpose for which it is processed, is erased or rectified without delay.

- The fifth data protection principle is that personal data processed for any of the law enforcement purposes must be kept for no longer than is necessary for the purpose for which it is processed and that appropriate time limits must be established for the periodic review of the need for the continued storage of personal data for any of the law enforcement purposes.

- The sixth data protection principle is that personal data processed for any of the law enforcement purposes must be so processed in a manner that ensures appropriate security of the personal data, using appropriate technical or organisational measures (and, in this principle, "appropriate security" includes protection against unauthorised or unlawful processing and against accidental loss, destruction or damage).

Staff should also be aware of and adhere to the Caldicott Principles (1997, 2013) which set out the best practice guidelines relating to the handling and sharing of information that organisations should follow to ensure that information that can identify a patient is protected and only used when it is appropriate to do so.

As defined by both the DPA 2018 and the Caldicott Principles, the use of information is always a risk and all appropriate legal, technical and physical security measures should be in place to ensure that audit data is processed safely and securely. In accordance with this, all audit data must be stored on the Isle of Wight NHS shared network drive or on an encrypted media device. Encrypted memory sticks and laptops are available from the IM&T department on request, and will be issued where it is deemed appropriate. The use of unencrypted removable media devices (such as unencrypted memory sticks) is strictly prohibited.

In line with the Department of Health publication Records Management: NHS Code of Practice part 2 (2009) the Trust will retain "audit records" for a period of five years.

Clinical audit activity must also conform to the requirements of the NHS Confidentiality Code of Practice (2003) which states that "Patients must be made aware that the information they give may be recorded, may be shared in order to provide them with care, and may be used to support local clinical audit" (page 21). If patients have been so informed, Section 251 of the NHS Act 2006 makes provision for the collection of patient identifiable data for the purposes of clinical audit; however the Trust would advocate that best practice should be used and all

clinical audit data must be anonymised (or pseudononimised) unless there is a compelling reason not to do so.

All clinical audit reports and presentations will be completely anonymised, i.e. not mentioning the names of patients or clinicians. Any discussions taking place in clinical audit meetings will also be bound by confidentiality.

7.2.7 Confidentiality agreements

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 who are on honorary contracts, volunteers, indeed patients and the public. It is important that they understand the "rules" which apply to the practice of clinical audit, so training is an important consideration. It is also recommended that individuals in this situation sign a confidentiality agreement, as outlined in Appendix B

7.2.8 Ethics and consent

Clinical audit projects do 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 audits, service evaluations and quality improvement activities carried out in the Trust must be consistent with ethical principles, that is, actually benefit patients and patient care and minimise any burdens on or risks to patients

7.2.9 Dissemination

Completed audits where appropriate will be discussed and presented at speciality audit or team meetings, where action plans must be agreed and a commitment to re-audit made if appropriate in a designated time.

The individual Care Group's Quality, Risk and Patient Safety Committees must review results of audits, and act on findings appropriately, if concerns arise following review of outcomes. Should escalation be required, this should be taken forward by Care Group leads to Care Group Leadership Meetings, and appropriate issues should form a risk register entry.

Completed audits are to be presented by the audit teams to the Clinical Effectiveness sub-Committee.

Any significant issues arising relating to work processes, should be put forward to be considered for inclusion on the Trusts internal audit programme via the Clinical Effectiveness sub-Committee.

7.2.10 Reporting

All clinical audit projects must have a report, and if necessary an action plan. Standard templates are available on the intranet at http://intranet.iow.nhs.uk/Home/Corporate-

Support/Patient-Safety-Experience-Clinical-Effectiveness/Effectiveness/Clinical-Audit/Clinical-Audit-Templates or via the Clinical Effectiveness Team.

7.2.11 Action plans

Where the results of a clinical audit indicate sub-optimal practice, an action plan should be produced. The format for a project action plan is provided below and is also included in the report template.

Action plans must contain the following information:

- Project title
- Action plan lead
- Planned date of re-audit
- Recommendations and associated actions
- Action by date
- Person responsible for completion of action (Name and grade)

The action plan should:

- Include routes of escalation if difficulties in implementation are encountered.
- Include the identification of local barriers to change, and organisational or resource constraints which preclude implementing
- Be specific, measurable and achievable/realistic. They should have clear implementation timescales with identified leads for each action.
- must be approved by the relevant head of service or department

Not all clinical audits will require an action plan e.g. where an audit shows that standards are being met or guidance followed. In this case, an explicit statement saying 'no further action required' should be included in the audit summary report and a reason given for no future re-audit.

The main purpose of clinical audit is to deliver improvements in clinical practice. A systematic approach to the implementation of clinical audit action plans is therefore strongly advised using the appropriate forums i.e. Speciality audit meetings, Care Group Leadership Meetings.

The Care Group Leadership Meeting will monitor the implementation of actions, ensuring that any identified changes are incorporated into relevant business plans as appropriate.

7.2.12 Re-audit

Re-audit is an important stage in the audit cycle. It determines whether agreed actions have been implemented according to the action plan.

Where an initial audit has identified actions to be taken – the Trust would expect a re-audit to be undertaken following a period of implementation of the action plan. In the event of the audit's

lead leaving the Trust, it will be the responsibility of the sponsor to ensure that the re-audit is undertaken.

7.2.13 Clinical audit reports to the Quality Committee

Quarterly reports are provided for the Quality Committee on clinical audit activity at the end of each quarter. The quarter 4 report will also include a summary of the preceding year's audit activity.

Reporting schedule is detailed in the table below

	Clinical Effectiveness sub-Committee	Quality Committee
Annual report (included in Q4 report)	April	May
Annual Audit Programme	April	May
Audit Reports	Quarterly	Quarterly

8. Consultation

Previous versions of this policy have been consulted on across the Trust. The policy has previously been discussed at the Safety, Experience and Effectiveness Committee, Risk Management Group and the Policy Management Committee prior to approval at Executive Board. This version has been revised in line with HQIP best practice guidance

9. Training

9.1 Overall organisational approach

Provision of clinical audit education and training are key to the delivery of this policy in order to promote clinical audit activities that are led by healthcare professionals.

9.2 Provision of clinical audit training

This Clinical Audit Policy does not have a mandatory training requirement but the following non mandatory training is recommended, Clinical Audit (e-learning module), and education sessions can be provided via the Clinical Effectiveness Team.

The Trust will make available suitable training, awareness or support programmes to all clinicians regarding the Trust's systems and arrangements for participating in clinical audit. This can be accessed from the Quality Advisors, in the Clinical Effectiveness Team.

9.3 Employment and development of Quality Advisors

The Trust will employ Quality Advisors who are suitably skilled in clinical audit to support its programme of clinical audit activity. The Trust will also ensure that these staff have access to further relevant training in order to maintain and develop their knowledge and skills.

10. Monitoring compliance and effectiveness

The Quality Advisors working with the individual Care Groups will monitor the clinical audit programme, and reports will be provided quarterly on progress against the programme at the Care Group Quality, Risk and Patient Safety Committee. Failure to move audits through the cycle will be highlighted to the Clinical Director and Head of Nursing and Quality, and support sought by the Care Group to enable completion of project.

The Clinical Effectiveness sub-Committee will also receive a quarterly update on progress against the programme. The Trust Audit and Quality Committees will also receive updates against the National and Local Audit Programme.

The Trust aims to ensure that its healthcare and facilities are not discriminatory and, wherever possible, attend to the physical, psychological, spiritual, and social and communication needs of any patient or visitor showing no discrimination on the grounds of ethnic origin or nationality, disability, gender reassignment, marital status, age, sexual orientation, race, trade union activity or political or religious beliefs.

The process for determining choice of clinical audit projects, and the manner in which project patient samples are drawn up, should not inadvertently discriminate against any groups in society based on their race, disability, gender, age, sexual orientation, religion and belief. Any person who has concerns regarding ethics of clinical audit activity within the Trust should refer them in the first instance to the Clinical Effectiveness sub-Committee, who may require equality impact assessment to be undertaken and/or equality data to be collected as part of clinical audits in order to determine whether any particular groups of patients are experiencing variations in practice.

Commissioners are actively involved in monitoring the effectiveness of clinical audit through contract based meetings, contractual arrangements in place ensure that commissioners are able to enquire about quality issues and utilise contractual levers where concern is raised.

10.1 Monitoring the implementation of the policy

The Clinical Effectiveness sub-Committee will monitor whether:

- The Care Group Quality, Risk and Patient Safety Committee are discharging their responsibilities for clinical audit
- staff are receiving training

- there is a rigorous system for determining what goes into the annual clinical audit programme
- stakeholders are being involved
- projects are approved and registered
- project are standards-based and conducted in line with this policy
- projects are meeting data protection and confidentiality guidelines
- results are being reported and disseminated
- action plans are being agreed and implemented

.

The individual Care Group's Quality, Risk and Patient Safety Committee must review the results of audits, and act on findings appropriately. If concerns arise following a review of outcomes, and escalation is required, escalation would be to the Care Group Leadership Meeting, and an appropriate risk register entry made.

11. References

- General Data Protection Regulations 2018
- Health Act (2009)
- National Health Service Act (2006)
- Records Management: NHS Code of Practice part 2 (2009)
- Burgess R and Moorhead J *'New Principles for Best Practice in Clinical Audit'*. Radcliffe Publishing, 2011
- Confidentiality NHS *Code of Practice part 2* (2009)
- General Medical Council *Good Medical Practice* (2013) http://www.gmc-uk.org/guidance/good_medical_practice.asp
- HQIP *'Criteria and indicators of best practice in clinical audit'.* Radcliffe Publishing, 2012
- Quality Account Toolkit 2010/11

Appendix A

Key Definitions

Audit team – the team of clinicians undertaking the audit

CEsC - Clinical Effectiveness sub-Committee

CEL – Clinical Effectiveness Lead

Clinical Audit Sponsor – the lead clinician responsible for an audit project. This is usually a consultant but can be any member of senior clinical staff. The audit sponsor takes on overall responsibility for ensuring the audit project is completed if the audit team is unable to do so i.e. by leaving the Trust.

CORP - Clinical Outcome Review Programmes

CQC - Care Quality Commission

DME - Director of Medical Education

DPA - Data Protection Act

EEA - European Economic Area

HQIP - Healthcare Quality Improvement Partnership

MEM - Medical Education Manager

NCAPOP - National Clinical Audit and Patient Outcomes Programme

NICE - National Institute for Health and Care Excellence

Quality Account – produced every year and published on the Trust website. It contains information about how the Trust has measured up to key quality and safety standards over the year. It also looks in detail at patient safety, the effectiveness of treatments and the feedback from patients.

Appendix B

Confidentiality agreement

This declaration must be signed by any person who is not employed by the [name of organisation], or deemed an honorary employee through association with the appropriate department of the [academic body], who will be reviewing patient-related information for the purposes of clinical audit.

Declaration

I hereby declare that I fully understand that all patient-related information to which I have access, whether held on computer or in written form or given to me verbally, is confidential and I undertake never to divulge information to anyone without the authority of a senior member of administrative staff. I understand that this includes the divulging of information to the police.

I also understand that the names, addresses and details of patients contained in any documents or indexes are confidential and must not be accessed or divulged for personal interest or gain, or any other purpose other than healthcare business.

By signing this form I accept that I have been informed that under the provisions of the Data Protection Act 1998, unauthorised disclosure of data may result in personal prosecution.

Name	
Project title:	
Post:	Department:
Email address:	
Mobile/telephone no:	
Signature and date:	
Witnessed by and date:	

Appendix C

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

Document title	**Clinical Audit Policy**

Totals	**WTE**	**Recurring £**	**Non Recurring £**
Manpower Costs	**Resources are already deployed and there will be no further resourcing impact**		
Training Staff			
Equipment & Provision of resources			

Summary of Impact: This policy will ensure that clinical audit is embedded across the Trust to ensure the delivery of high quality patient care.

No cost implication due to minimal change in current processes, policy reviewed to support national best practice guidance and HQIP requirements.

Risk Management Issues: Lack of correct methodology for clinical audit may in some circumstances fail to identify areas of poor performance, having a negative impact on patient care.

Benefits / Savings to the organisation: Monitoring performance by undertaking clinical audit will support service improvement, and ensure delivery of high quality patient care which would support a possible reduction in litigation and complaints financial redress.

Equality Impact Assessment

- Has this been appropriately carried out? YES/NO
- Are there any reported equality issues? YES/NO

If "YES" please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you

have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	WTE	Recurring £	Non-Recurring £
Operational running costs			
Totals:			

Staff Training Impact	Recurring £	Non-Recurring £
Totals:		

Equipment and Provision of Resources	Recurring £ *	Non-Recurring £ *
Accommodation / facilities needed		
Building alterations (extensions/new)		
IT Hardware / software / licences		
Medical equipment		
Stationery / publicity		
Travel costs		
Utilities e.g. telephones		
Process change		
Rolling replacement of equipment		
Equipment maintenance		
Marketing – booklets/posters/handouts, etc		
Totals:		

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	

Appendix D

Equality Impact Assessment (EIA) Screening Tool

Document Title:	Clinical Audit Policy
Purpose of document	
Target Audience	*All members of staff who are involved in or undertake clinical audit*
Person or Committee undertaken the Equality Impact Assessment	*Lead for Clinical Effectiveness*

1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	**Negative Impact**	**Reasons**
Gender	Men			*No change*
	Women			*No change*
Race	Asian or Asian British People			*No change*
	Black or Black British People			*No change*
	Chinese people			*No change*

	People of Mixed Race			*No change*
	White people (including Irish people)			*No change*
	People with Physical Disabilities, Learning Disabilities or Mental Health Issues			*No change*
Sexual Orientation	Transgender			*No change*
	Lesbian, Gay men and bisexual			*No change*
Age	Children			*No change*
	Older People (60+)			*No change*
	Younger People (17 to 25 yrs)			*No change*
Faith Group				*No change*
Pregnancy & Maternity				*No change*
Equal Opportunities and/or improved relations				*No change*

Notes:
Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

If you have indicated that there is a negative impact, is that impact:			
		YES	**NO**
Legal (it is not discriminatory under anti-discriminatory law)			
Intended			

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:	
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:	
3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?	
Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	
Date Initial Screening completed	