Southern Hampshire
PRIMARY CARE ALLIANCE

Clinical Governance: Clinical Audit Procedure

1.3

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Contents

1.1 What is Clinical Audit?

Clinical audit is the process of health professionals evaluating the quality of care they provide by comparing current practice against pre-determined best practice. This procedure details how audits are selected and will guide staff through the clinical audit process.

"A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement in healthcare delivery". (Healthcare Quality Improvement Programme (HQIP),2016).

Clinical audit is a statutory requirement set out by NHS England, through the NHS standard contract, and the Care Quality Commission (CQC), which requires participation in local and national audits.

In addition to be part of good practice, we also are required to clinically audit the work provided by our clinicians to ensure that we are providing safe and effective quality assured care.

Through Clinical Audits, SHPCA will be able to:

- Provide an opportunity for identifying any learning needs and therefore ability to feedback to both staff and the wider service; improvements can be made
- Facilitate being able to identify patterns of issues that may arise allowing services to be shaped for the future.
- Achieve revalidation and appraisal of clinical staff
- Achieve a review process with regards to effectiveness of service
- Implement decisions made with best interests of patients with regards to their journey

In summary, as per the seven pillars of clinical governance, Audit will help analyse clinical effectiveness, risk management, patient experience, communication, resource effectiveness, strategic effectiveness and learning effectiveness.

End to End Reviews will also form part of the Clinical Audit programme for SHPCA. These will be undertaken regularly as required by any commissioned contracts.

1.2 The Clinical Audit Cycle

The component parts of clinical audit are:

- Selecting a topic
- Agreeing standards
- Comparing practice with standards
- Changing practice
- Re-audit to make sure practice has improved ('closing the loop')

An Audit is a continual process and considered as a cycle as illustrated in figure 1 below:

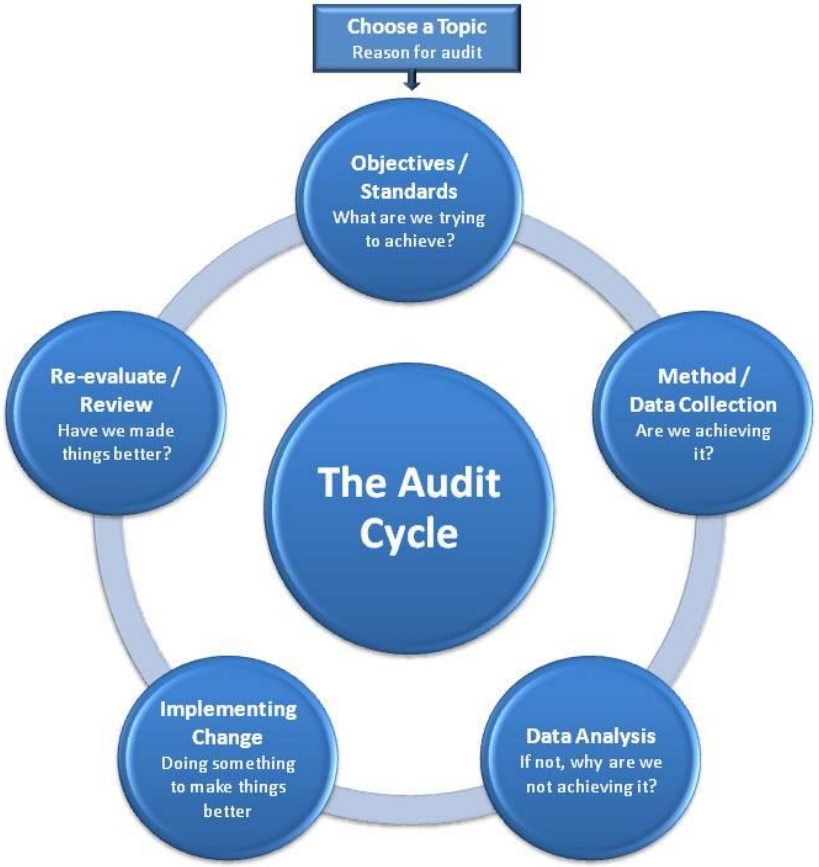

Figure 1

1.3 Choosing a Topic

Before undertaking an audit, any proposed audits should be discussed with the Head of Quality of and Governance to ensure it is appropriate and not covered by an existing audit. An appropriate and achievable audit topic should be chosen which focuses on processes with the aim to improve patient care/ outcome. For each Clinical Audit being undertaken, the audit template in appendix 1 and 2 should be followed, with the exception prescribing audits. Once the audit has been agreed and an audit number given, collection of data can be undertaken. A sample size should be established before an audit is undertaken, such as a group of patients with a particular condition or undertaking a specific treatment. The sample size should be sufficient to enable clinicians/ senior team to implement changes based on the findings. If appropriate other stakeholders should also be involved such as patients, carers, and other organisations where the project extends outside the SHPCA. Aims and objectives of the audit should be set before an audit is undertaken.

1.4 Setting Audit Standards

Standards of best practice may exist locally or nationally in the form of guidelines or protocols. National standards are available for certain treatments and conditions in the form of NICE, HQIP or Royal College / professional body guidelines and are also incorporated into large-scale service delivery documents such as the NSFs.

If there are no recognised standards available from these sources, audit specific standards need to be developed by the clinicians undertaking the audit. The standards should relate to the audit objectives and should always be based on, the most up-to-date evidence of what constitutes best practice. A literature search will need to be undertaken to identify relevant evidence from which

to develop the standards. SHPCA will utilise the RCGP toolkit for their existing audits. http://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/urgent-and-emergency-care.aspx (this is at Appendix 1).

Additional evidence-based tools will be applied to other audits as these are developed.

There is no single way of writing a standard, but any well-written standard should be specific, and evidence should be readily accessible and available to indicate whether this standard has been met.

It is normal to set the target at 100% as, if the standard is best practice; everyone is entitled to receive it. However, there are occasions when the target may be set lower than 100%. For example, the standard would be set at 0% if it is referring to something that will never be done.

1.5 Data Collection

It is important that only the minimum amount of data is collected and that it is precise. Prior to the audit the staff involved need to establish exactly what data needs to be collected, how it will be collected and over what time period the audit needs to be carried out.

Data may be collected either retrospectively to provide an indication of the care provided during a period in the past, or concurrently to provide more immediate feedback on current practices.

1.6 Action Plans

All audit projects should have a SMART (Specific, Measurable, Achievable, Relevant, Timely) action plan that identifies:

- What needs to be done
- Who is going to do it
- When (target dates)
- How it will be done
- When a re-audit will be carried out

1.7 Dissemination and Reporting

Once an audit is complete, an audit summary should be created, detailing what was done, the findings, any recommendations and action plans.

Audit results should be shared locally with stakeholders, as per contractual arrangements.

Progress against action plans should be monitored locally to ensure improvements are implemented.

1.8 Summary internal process for clinical audit within SHPCA

Head of Governance, Clinical Director or Head of Clinical Service randomly selects cases to audit, ensuring a reasonable spread of age and clinician input. In addition, clinicians can ask for specific cases to be audited. Where needed rotas will be in place to share audit workload between the senior team and Directors. A rota will be in place for Director (GP) assurance/oversight and guidance of any audits, particularly where a non-GP is auditing a GP's consultation (an example of

this is at Appendix 3). Feedback will be given to the auditor and used to develop their own knowledge and practice.

SHPCA also conducts routine and national prescribing audits to improve medication safety, promote antimicrobial stewardships and reduce rates of potentially hazardous prescribing. This is primary led by the Lead Clinical pharmacist and reported to the Head of Quality and Governance.

EMIS Clinical Data: SHPCA is the Data Controller so the audit process will entail identification of random cases and use of template by auditors at Appendix 1. All feedback will be collated centrally by Head of Quality & Governance.

Adastra Data: When using Adastra clinical system for CAS activity, SHPCA is not the data controller. Records access will be via data sharing agreement with South Central Ambulance Service (SCAS) who are the Data Controller for relevant records which will be shared in line with Caldicott Guidelines and data/IG requirements. Audit process will be carried out by SHPCA Senior Team & GP Directors using internal CAS audit template (Appendix 2).

1.9 Frequency of Audit – Individual Clinicians

All new staff will have at least 2 cases audited within their first month of working in the service.

Each practitioner will be audited at least once in the month they have practiced, wherever possible and/or to ensure the appropriate percentage of consultations are audited in line with professional good practice or contractual requirements. A re-audit should be completed once the action plan has been fully implemented. Any data collected by clinicians whilst working for SHPCA remains the property of the SHPCA at all times.

- **Good/Notable Practice**

  Good practice will be identified and shared with the relevant clinicians and with the wider audience.

- **Managing Risk**

  Where immediate action is needed the Clinical Lead Director or senior team member as appropriate will enact this at the time of audit if there is any level of clinical risk.

- **Learning & Feedback**

  Any other points of learning will be fed back to the clinician in a specific feedback form, by the Lead Director of the service audited, or other appropriate member of the senior management team (COO, HOQ or HOCS). Each clinician will have the opportunity to respond to their feedback which can be used formally for their own records, as well as service and practice development in service. A template is at Appendix 4 that can be used for feedback.

- **Sharing of Audit Results**

  Data will be collated, and the results of audit regularly shared within services, to the Board and with commissioners. Audit should be seen as a process that improves and enhances practice.

- **Concerns with Practice**

Where there is evidence of ongoing concerns that warrant performance management, then appropriate investigatory policies will be enacted, and professional bodies referred to, if required. Any referrals to the NMC must be processed through the Head of Quality & Governance and any referrals to the GMC must be processed through the Lead Director.

1.10 Other Resources:

- Managing Incidents policy
- Freedom to Speak Up, Just Culture & Whistleblowing
- Managing Performance
- HR Lifecycle of an Employee Handbook.

1.11 Training

Training for staff undertaking Clinical Audits will be provided on an Ad hoc and need basis by the Quality and Governance team or Senior team.

1.12 Ethics, Patient Consent and Equality & Diversity

Unlike research, clinical audit projects do not need to be submitted to the Local Research Ethics Committee for ethical approval. However, clinical audit must always be conducted within an ethical framework. At a practical level this means ensuring patient confidentiality at all times by abiding by the Data Protection Act (1998) and the Caldicott Principles (1997).

Audit data collected should be anonymised wherever possible, removing identifiers such as patient/service username or other unique/semi-unique details such as post code, date of birth etc. Good practice in clinical audit states that when data is collected about a patient/service user a unique identification code should be assigned to that data.

Any patient-identifiable clinical audit data must be kept secure, e.g., by locking audit proformas away in a filing cabinet; or password protecting electronic files. Once the audit has been carried out and written up, all completed audit proformas and patient identifiable data should be destroyed.

Appendix 1- Blank Clinical Audit Template (Based on RCGP)

Month	Auditor	Clinicians Name	NHS Number	Type of Consultation GP/ANP/PN/HCA (if NOT F2F note Tel/Vid)	Appropriate for the Service (inc details 111 vs GPEA)2	Appropriate Physical/ Examination (where applicable)	Appropriate Management	Appropriate Red flagging/ signposting/ safety netting	Calculated Score	% Score	Please add comments/suggestions for improvements/ feedback.	Outcome	SHPCA Director Check (non GP Audits only)	Any notes/feedback for non-GP Auditor
						0	0	0	0/6	0.00%				
						0	0	0	0/6	0.00%				
						0	0	0	0/6	0.00%				
						0	0	0	0/6	0.00%				
						0	0	0	0/6	0.00%				
						0	0	0	0/6	0.00%				
						0	0	0	0/6	0.00%				
						0	0	0	0/6	0.00%				
						0	0	0	0/6	0.00%				
						0	0	0	0/6	0.00%				
						0	0	0	0/6	0.00%				

Appendix 2– Audit Template for CAS Clinicians

Case ID			Clearly elicits reason for call	IDs emergency or serious situations	Appropriate history taking or use of TAS					Full exam. of mental and physical health	Draws appropriate conclusions	Makes appropriate management decisions			Appropriate prescribing behaviour			Displays adequate safety netting	Scoring		Comments		
Clinicians Nama	Adastra Ref	Month	Identifies the main reason for contact	Asks appropriate questions to exclude such situations inc. red flags	Records history of presenting complaint	Records past medical history	Records regular medication	Records allergies (or none)	Records medication for current condition (inc. OTC)	Targeted method of information gathering or algorithm use	Records appropriate or diagnosis differential	Treatment to appropriate diagnosis	Appropriate disposition (treatment or onward referral	Correct priority given	Appropriate prescribing	Prescribing module used	Relevant advice given	Advice when to call back including worsening instructions	Calculated Score	% Score	Please add comments where applicable	Actions	Outcomes
			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0/32	0.00%			
			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0/32	0.00%			
			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0/32	0.00%			
			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0/32	0.00%			
			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0/32	0.00%			
			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0/32	0.00%			
			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0/32	0.00%			
			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0/32	0.00%			
			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0/32	0.00%			

Appendix 3 - Clinical Governance Audit Director Rota 2022

Month	Named Clinical Director Lead Auditor
January	Janet Naylor
February	Dean Hatfull
March	Kirstine Haslehurst
April	Kathryn Bannell
May	Raj Laly
June	Dean Hatfull
July	Janet Naylor
August	Kathryn Bannell
September	Janet Naylor
October	Dean Hatfull
November	Janet Naylor
December	Kathryn Bannell

Director of the month is support/guidance and /or additional assurance for any audit activity.

Appendix 4 - Clinical Audit Feedback Template for Staff

Clinical Audit Feedback May20.do