

Clinical Audit Policy

Effective: January 2011

Review: January 2014

1. Introduction

- 1.1 The purpose of this policy is to develop and sustain a culture of best practice within the Trust through the clinical audit process. This Policy is aimed at all Trust Staff participating in Clinical Effectiveness and Audit.
- 1.2 The expectation for healthcare professionals to participate in regular clinical audit was first established in the 1989 Government White Paper, 'Working for Patients'. This has been reinforced and extended by a succession of key national publications, including:
- The New NHS — Modern, Dependable (Department of Health, 1997)
 - A First Class Service (Department of Health, 1998)
 - Clinical Governance — Quality in the NHS (Department of Health, 1999)
 - Learning from Bristol: the report of the public inquiry into children's heart surgery at Bristol Royal Infirmary 1984–1995 [the 'Kennedy Report'] (Department of Health, 2002)
 - Good Doctors Safer Patients (Department of Health, 2006)
 - Trust Assurance & Safety (Department of Health, 2007)
 - The NHS Next Stage Review Final Report, High Quality Care for All [the 'Darzi Report'], (Department of Health, 2008).
- 1.3 The Trust is committed to the aims of clinical audit in improving patient outcomes by enhancing professional practice and the general quality of services delivered based on the principles outlined in section 2.

2. Principles

The Trust philosophy for clinical audit is to:

- Ensure that audits are relevant and ensuring that the services provided are safe, of a high quality, and meet local, regional and national standards
- Encourage audit to be utilised to drive and monitor clinical improvement and changes in practice
- Ensure that all staff are supported and encouraged to participate in clinical audit
- Encourage multidisciplinary audit across the Trust
- Encourage patient, carer and public involvement in the audit process
- Encourage cross-organisational audit involving the local Health Economy.

3. Purpose

The purpose of this policy is to set out a framework for the conduct of clinical audit within the Trust.

- 3.1 Clinical audit is a key and essential component of clinical governance within the Trust and involves all clinicians to ensure that patients receive optimum care based upon the best available clinical evidence.
- 3.2 The definition endorsed for Clinical Audit by the National Institute for Health and Clinical Excellence (NICE) and the Care Quality Commission is that it is “A quality improvement process that seeks to improve the patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structures, 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” (NICE, 2002).
- 3.3 The Healthcare Commission introduced an Engagement in clinical audit indicator in 2008 which placed the following expectations on Trusts:
 - To participate in local and/or national audits of the treatment and outcomes for patients in each clinical directorate covered by the Trust
 - To have a clinical audit strategy and programme related to both local and national priorities with the overall main aim of improving patient outcomes
 - To make available suitable training, awareness or support programmes to all clinicians regarding the Trust's systems and arrangements for participating in clinical audit
 - To ensure that all clinicians and other relevant staff conducting and/or managing clinical audits are given appropriate time, knowledge and skills to facilitate the successful completion of the audit cycle
 - To undertake a formal review of the local and national audit programme undertaken in the Trust to ensure that it meets the organisation's aims and objectives as part of the wider quality improvement agenda
 - To provide the Trust's management and governance leads with regular reports on the progress being made in implementing the outcomes of national clinical audits, and review the outcomes, with additional or re-audits being conducted where necessary.

4. Definitions

It is important to distinguish clinical audit from data collection exercises and research projects.

<i>Review</i>	Where does my practice stand at the moment? (No comparison with a standard)
<i>Research</i>	What should I be doing? (To establish best practice)
<i>Clinical Audit</i>	Am I doing what I should be doing? (Comparison with best practice standard)

5. Duties

Structure and responsibilities

5.1 Chief Executive

The Chief Executive has overall responsibility for the strategic direction and operational management of the Trust and takes overall responsibility for this policy.

5.2 Trust Board

The Trust Board has a role in driving quality assurance, compliance, internal audit and “closing the loop” in accordance with Healthcare Quality Improvement Partnership (HQIP) document: Clinical Audit: A simple guide for NHS boards (2009a) available at www.hqip.org.uk .

5.3 Medical Director

The Medical Director is the Executive Lead for Clinical Audit and hence has ultimate responsibility for the delivery of the clinical audit programme.

5.4 Clinical Governance and Quality Committee

The Clinical Governance and Quality Committee is the Executive Committee with responsibility for clinical audit.

5.5 Clinical Effectiveness, Audit and Guidelines Committee

The Clinical Effectiveness, Audit and Guidelines Committee is a sub-committee of the Clinical Governance and Quality Committee and has responsibility for: developing a strategy for clinical audit and effectiveness which includes participation in both national and local audit, establishing a system for the recording of audit activity, stimulating the evaluation of the implementation of change through reaudit and ensuring appropriate arrangements are in place for monitoring the implementation of prioritised clinical effectiveness and audit programmes. The strategy will be reviewed

every twelve months and includes an Audit Plan for the twelve months period.

5.6 Clinical Governance and Risk Department (CGARD)

Within CGARD, the clinical effectiveness and audit is managed by the Clinical Effectiveness and Quality Manager and is supported by the Clinical Effectiveness Manager for :

- Supporting the audit of Trust Priorities
- Providing training materials in relation to the concepts of clinical audit and the basic skills required to undertake clinical audit
- Establishing arrangements and providing information on the reporting of audit activity across the Trust.

5.7 Lead Clinicians (Directorate)

Each Clinical Directorate has an identified lead clinician for clinical audit who has responsibility for:

- Ensuring that clinical audit is embedded within the culture of the Directorate
- Providing an annual clinical audit report to the Clinical Effectiveness, Audit and Guidelines Committee detailing progress made and plans for the next twelve months
- Establishing Directorate priorities for clinical audit on an annual basis
- Promoting effective clinical audit based on evidence-based practice
- Ensuring audit projects are logged on the Trust's clinical audit database with all appropriate outcomes recorded on completion of audit projects
- Ensuring there is a system in place for the implementation of audit recommendations with re-audit undertaken to "close the audit loop" and highlight demonstrable improvements to patient care
- Identify any training needs within the Directorate for the conduct of audit projects
- Allow time for regular multidisciplinary meetings to discuss indicators of clinical quality and audit projects, with records of attendance, topics considered and actions agreed (with responsibility for action). Directorates should support this by explicitly allocating time for staff to attend multidisciplinary audit meetings
- To report on their annual clinical audit activity and highlight any changes in practice as a result of findings in their annual reports.

5.8 Clinicians

The Trust is committed to ensuring all clinicians are actively involved in the audit process. Professional staff are individually accountable for ensuring they audit their own practice as defined by their codes of conduct.

6. Commitment to Stakeholder Engagement, Collaboration and Partnership

6.1 Involving Patients and the Public

The Trust is committed to 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.

6.2 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.

6.3 Involving medical students and F1 / F2 doctors

The Trust has established an annual award for F1 and F2 doctors which recognises good clinical audit practice through longitudinal projects.

7. Prioritising Clinical Audit Projects

7.1 Trust Audit Programme

The Trust will audit projects against the most appropriate standards of performance. Consequently, the Trust clinical audit programme will consist of two key components i.e. mandatory and discretionary audit.

7.1.1 Mandatory Audits

These are audits that are compulsory for the Trust to demonstrate compliance for example,

- NICE Guidance for example Technology Appraisal Guidelines (TAGs)
- National Confidential Enquiries' recommendations
- Key policies relating to NHS Litigation Authority requirements
- Participation in the National Clinical Audit Patient Outcome Programme
- Care Quality Commission
- CQUIN indicators.

7.1.2 Discretionary Audits

These are audits which are not necessarily national priorities, but are important to the Trust in delivering patient care. All audit

projects must contribute to the overall objectives of the audit programme and look to improve patient care / service delivery.

7.1.3 In terms of support for clinical audit, CGARD will focus on assisting with mandatory requirements.

7.2 Directorate audit activity

The Trust expects that Directorate clinical audit activity will be driven by key Trust performance targets and priorities.

Additional activity can be incorporated into the Directorate's clinical audit activity to reflect local priorities for example audits performed following a complaint, local incident, local guidelines, identified deficiencies in care, morbidity and mortality issues.

8. Process for ensuring appropriate standards of performance are audited

8.1 When undertaking an audit project, the lead clinician for the project should notify CGARD using the R1 Form (Appendix 1). CGARD will subsequently maintain a database of all registered audit activity by Directorate.

8.2 Each audit project undertaken should ideally have a topic, a supervisor, a coherent plan and a timescale. The supervisor is responsible for overseeing the data collection, dissemination of findings, acting on recommendations including agreement of local action for performance development and reaudit. There are six key stages within an audit project which are referred to as the audit cycle (these are outlined in Appendix 2) and each project should reflect "Criteria for Good Audit" (Appendix 3).

8.3 Wherever possible, prospective clinical audit should be the norm as it allows for accurate real time accrual of data that reflects current rather than historical practice. Data collection should therefore be 100% accurate both in volume and detail. Retrospective clinical audit can however act as an historical benchmark, but is of most use if a critical incident arises be this a complaint, litigation, adverse event or serious adverse outcome and a review of practice is required urgently.

8.4 Clinical audit involves collecting information about patient care and treatment, but more than that it is about ensuring quality i.e. making sure that we are doing the things we should be doing. Standards are written to state explicitly what those things are. Once you have selected a topic to audit, the next stage of the audit cycle is to set the standards by which you will measure your performance.

A standard is an explicit statement describing the quality of care to be achieved, which is **definable** and **measurable**. In order to effectively measure your performance, the standards developed need to be SMART (HQIP, 2009b):

Specific – clear and unambiguous
Measurable – easy to evaluate
Achievable – within your resources
Realistic – within service constraints
Timely – not out-of-date or inaccurate

The Trust takes the view that, wherever possible, registration of audit projects should include the adoption of credible evidence based standards but notes that standards do not always exist in relation to local projects in particular.

- 8.5 Clinical audits should be multidisciplinary wherever possible and there should be a commitment to reaudit to ensure that an evaluation is undertaken of any changes in practice to determine whether they have yielded improvements to patient care or service delivery.

9 Process for disseminating audit results / reports

- 9.1 Each completed audit must have a final report which should follow the structure and format outlined in Appendix 4.
- 9.2 When the final report has been produced a Form R3 (Appendix 5) must be completed for notification of the main outcomes and forwarded to CGARD and logged on the Trust's Clinical Audit database.
- 9.3 Where any deficiencies in practice are identified, action plans should be produced to address the deficiency. The action plans should detail corrective action required to achieve compliance, identify a lead with responsibility for achieving compliance and a timescale where appropriate.
- 9.4 If any barriers to change or organisational / resource constraints are encountered, the appropriate route of escalation should be identified.
- 9.5 The results of audit should be disseminated appropriately including presentations at specialty and directorate audit meetings where the findings should be discussed and action plans highlighted.
- 9.6 Where issues of significant non-compliance are identified, these should be placed on the Directorate's risk register and reported to the Corporate Governance Committee and Trust Board as appropriate including actions required for achieving compliance.
- 9.7 Clinical Directorates must provide an annual clinical governance report which is based on the seven pillars of clinical governance. One of the pillars relates specifically to clinical audit activity and Directorates are required to provide evidence of audit engagement at both national and local level including any changes in practice which have resulted in improvements to patients care / service delivery. The clinical audit report is presented to the Clinical Effectiveness, Audit and Guidelines Committee

by the Directorate audit lead clinician. A feedback letter is compiled by the Chair, Clinical Effectiveness, Audit and Guidelines Committee indicating elements of good practice and where improvements can be made.

- 9.8 The Trust is committed to ensuring the appropriate involvement of the local health economy and it engages in joint membership of both primary and secondary care Committees / Groups where appropriate.

10 Process for making improvements

- 10.1 All audits which have resulted in the development of action plans should be monitored by the appropriate Committee / Group in particular, audits involving key performance targets identified in policies, procedures and guidelines. In addition, as indicated in 9.7, Clinical Directorates must provide an annual clinical governance report which is based on the seven pillars of clinical governance.
- 10.2 Reaudit must feature within action plans where the need for improvements have been made to ensure that any interventions / changes in practice have resulted in improved practice.
- 10.3 All Clinical Directorate clinical governance reports which include details of clinical audit activity are posted on the Clinical Governance website. In addition, the results of audits / reaudits are disseminated accordingly through clinical audit meetings, correspondence, intranet site posting and if required formal training events organised to ensure staff have all appropriate skills and knowledge to deliver the best quality care. Furthermore, if an audit necessitates the need for revisions to existing policies, procedures, clinical guidelines then the appropriate author should be contacted and the documentation amended accordingly.

11. Ethics and Consent

Whilst clinical audit projects should not require Research Ethics Committee approval they should be developed to ensure and maintain patients' rights, dignity, privacy and confidentiality. If clinicians are unsure about this then they should refer to "Ethics and clinical audit and quality improvement – a guide for NHS organisations" (HQIP, 2009c).

12. Training

- 12.1 The Trust will ensure that all clinicians within the organisation have the skills and knowledge to undertake clinical audit through the provision of training for staff. In particular, a training programme on clinical audit has been developed using BREEZE software which enables staff to either develop / refresh their knowledge and skills and provides an assessment to determine whether participants have learnt the key aspects relating to clinical audit.

12.2 Clinical staff who have particular projects can request advice and guidance from CGARD on a 1:1 basis.

13. Monitoring

Compliance with this policy will be monitored by the Clinical Effectiveness Manager who will undertake a six monthly audit of the Trust's audit register to ensure that audit activity is undertaken against the appropriate standards of performance and recorded in the appropriate format, that reaudit has taken place and improvements made as required.

The Clinical Governance reports by the Directorates will be monitored to ensure that they are in the correct format detailing their audit activity and published to facilitate organisational learning.

The Clinical Effectiveness, Audit and Guidelines Committee will receive the results of the audit, identify any gaps, develop action plans and monitor compliance until all issues have been resolved.

14. References

British Royal Infirmary Inquiry (2002). *Learning from Bristol. The report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*. London: The Stationery Office.

Clinical Governance Support Team (2005). *A Practical Clinical Audit Handbook*. London: Clinical Governance Support team.

Darzi, Professor the Lord (2008). *High Quality Care For All: NHS Next Stage Review Final Report*. London: Department of health.

DH (1997). *The New NHS – Modern, Dependable*. London: Department of Health.

DH (1998). *A First Class Service*. London: Department of Health.

DH (1999). *Clinical Governance – Quality in the NHS*. London: Department of Health.

DH (2006). *Good Doctors, Safer Patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients. A report by the Chief Medical Officer*. London: Department of health.

Healthcare Quality Improvement Partnership (HQIP) (2009a). *A simple guide for NHS Boards*. London: HQIP.

Healthcare Quality Improvement Partnership (HQIP) (2009b). *Criteria and Indications for best practice in clinical audit*. London: HQIP.

Healthcare Quality Improvement Partnership (HQIP) (2009c). *Ethics and Clinical Audit and Quality Improvement - a guide for NHS Organisations*. London: HQIP.

National Institute for Health and Clinical Excellence (2002). *Principles for Best Practice in Clinical Audit*. Oxford: Radcliffe Medical Press.

Author: Clinical Effectiveness Manager

Form R1 – Audit Registration Sheet

*This form is for registering audit projects which are about to be undertaken by staff, but **do not** require the assistance of the Clinical Governance & Risk Department, if you do require assistance please complete the **R2** form instead.
If the audit project has already been **completed**, please use form **R3** to register the Project.*

Directorate:			
Sub-specialty:			
Project Title:			
Project Supervisor: Please include name, phone, email, and location. (You may list others on the project, in which case please state who is the Supervisor.)			
Project Priority:	NICE <input type="checkbox"/> NSF <input type="checkbox"/> National Audit Programme <input type="checkbox"/> NCEPOD <input type="checkbox"/> Other Trust Priority <input type="checkbox"/> Other Directorate Priority <input type="checkbox"/> None of these <input type="checkbox"/>		
Please indicate which site this audit refers to: <i>(Click on a box to set or unset the options.)</i>			
Freeman <input type="checkbox"/> RVI <input type="checkbox"/> NGH <input type="checkbox"/> WGH <input type="checkbox"/> Dental Hospital <input type="checkbox"/> Centre for Life <input type="checkbox"/> Cross-site <input type="checkbox"/>			
Project Type?	Multi-disciplinary <input type="checkbox"/>	Uni-disciplinary <input type="checkbox"/>	
Disciplines:	Medical <input type="checkbox"/>	Nursing <input type="checkbox"/>	AHPs <input type="checkbox"/> Manager <input type="checkbox"/> Other <input type="checkbox"/>
Please name other groups:			
Cross organisational? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, specify: Other Acute <input type="checkbox"/> Community <input type="checkbox"/> Education <input type="checkbox"/>			
GP <input type="checkbox"/> Mental Health <input type="checkbox"/> Public Health <input type="checkbox"/> Social Services <input type="checkbox"/> Other (please specify below) <input type="checkbox"/>			
Does audit directly involve patients, carers or the public? <i>(i.e. recruiting their views)</i> Yes <input type="checkbox"/> No <input type="checkbox"/>			
Is Project:	First Audit? <input type="checkbox"/>	Re-audit? <input type="checkbox"/> →	Please provide, title and date of previous audit:
Title of evidence based criteria/standards: <i>(If NICE guidance, please include number, e.g. TAG 104, IPG 153, etc.)</i>			
Source:	NICE <input type="checkbox"/>	NSF <input type="checkbox"/>	National guidelines <input type="checkbox"/> Local guidelines <input type="checkbox"/> Other <input type="checkbox"/>
Please indicate the method(s) used to collect the data: <i>(you can choose more than one option)</i>			
Questionnaire <input type="checkbox"/>	Case Note Review <input type="checkbox"/>	Interview <input type="checkbox"/>	Critical Incident Monitoring <input type="checkbox"/>
Focus Group(s) <input type="checkbox"/>	Patient diaries <input type="checkbox"/>	Observation <input type="checkbox"/>	Other (please specify below) <input type="checkbox"/>
Start Date: <i>(dd/mm/yyyy)</i>		Planned Completion Date: <i>(dd/mm/yyyy)</i>	

Please send to: Clinical Governance and Risk Department, 3rd Floor, Peacock Hall, RVI

On completion of the audit project, please remember to send a copy of the final audit report to the Clinical Governance and Risk Department, together with form R3.

The Audit Cycle

Stage One: Selecting a topic

There can be many reasons for undertaking an audit project however the main reasons are perceived as being high risk, high cost, high volume, wide variation in practice or local concern. Topics for audit may originate from:

- NICE guidelines
- Confidential Enquiries
- National Services Frameworks
- National Audits / Royal Colleges
- Requirements of National Health Services Litigation Authority (formerly CNST)
- Reaudits
- Incidents captured by risk management process
- Complaints & Claims
- Risk assessments
- Case reviews
- Local guidelines and protocols.

Stage Two: Set standards

Clinical audit measures current practice against guidelines or performance criteria. Consequently, explicit evidence-based standards should be identified for each project.

Stage Three: Data collection

Numerous methods are available for both quantitative and qualitative data collection to determine whether current practice complies with the agreed standards. In addition, where appropriate, projects should recognise the need for active patient, carer and public involvement, and the involvement of other organisations in the local Health Economy. Where an area does not interact directly with the public they should ensure the involvement of service users.

Audit is primarily a snapshot in time of current practice. The sample should be small enough to allow for rapid data acquisition, but large enough to be representative. It is recommended that small-scale pilot projects are undertaken initially to identify any potential problems with the data collection method before embarking on the main study.

Stage Four: Analysis and reporting

Data analysis and reports should be produced which focus on all the key areas of the audit including recommendations and changes to practice as appropriate. Reports must be presented within a suitable timeframe and to a suitable standard (please see Advice on Best Practice below). When the final report has been

produced a Form R3 (available from Trust Intranet homepage, Clinical Governance, Audit Registration Forms), must be completed for notification of the main outcomes and forwarded to the Clinical Governance and Risk Department and logged on the Trust's Clinical Audit database.

Stage Five: Implementing Change / Making Improvements

The implementation of change is a key stage of effective audit and all affected parties must be informed of the results and understand the need for change and the changes recommended. A systematic approach should be adopted with each recommendation identifying the date by which it should be implemented and the person responsible for making it happen.

Stage Six: Reaudit

Once sufficient time has elapsed for changes to become implemented into practice, it is essential that a reaudit is undertaken to "close the loop" and demonstrate that improvements have been achieved, to patient care/ service delivery. It cannot be merely assumed that changes will always result in positive outcomes.

Reaudit will need to address whether standards remain realistic and appropriate. Data should be collected by the same method as previous and compared accordingly.

The clinical audit process is a continuous quality improvement process and is often referred to as an "audit spiral" with opportunities for change becoming less as practice improves.

General Information

Ethical Responsibilities

Whilst audit projects do not routinely require ethical approval, project leads should be mindful of potential ethical concerns and seek advice as appropriate, in addition to paying appropriate recognition to the Caldicott recommendations, (recommendations available from, Trust Intranet homepage, Clinical Governance, Audit Registration Forms, Caldicott Principles).

Advice on Best Practice

The Clinical Governance and Risk department publish a series of "How To" leaflets on their intranet web site containing advice on best practice for planning and undertaking audit projects, devising questionnaires, running Focus Groups and writing audit reports.

Criteria for “Good Audit”

1. Should be part of a structured programme.
2. Topics chosen should in the main be high risk, high volume or high cost or reflect National requirements e.g. NICE guidelines, NSFs, National Clinical Audit Programme and Confidential Enquiries.
3. Service users should be part of the clinical audit process.
4. Should be multidisciplinary in nature.
5. Clinical audit should include assessment of process and outcome of care.
6. Standards should be derived from good quality guidelines.
7. The sample size chosen should be adequate to produce credible results.
8. Managers should be actively involved in audit and in particular in the development of action plans from audit enquiry.
9. Action plans should address the local barriers to change and identify those responsible for service improvement
10. Reaudit should be applied to ascertain whether improvements in care have been implemented as a result of clinical audit.
11. Systems, structures and specific mechanisms should be made available to monitor service improvements once the audit cycle has been completed.
12. Each audit should have a local lead.

(Taken from Practical Clinical Audit Handbook, NHS, 2005)

Clinical Audit Report Writing Structure and Format

Audit reports should contain the following headings and contents:

Title Page

This will include the title of the report, who has written it and the date it was written. Trust logo should be on the top right hand corner.

Contents Page

This lists the headings in the report together with the page numbers to which they refer.

Executive Summary

This should contain an overview of the message in the report, with a clear summary of the recommendations.

Introduction/Background

These can be two separate sections or combined. It should set the context of the report and define the scope and any limitations of the study.

Aims and Objectives

This should clearly identify what you want to achieve.

Standards

This section documents any standards which are being used to measure current practice against. It should include the relevant evidence base from which the standards are taken.

Methodology

This section details how the study was undertaken. It should include how the information was collected, when project was undertaken, where it was taken from and how much e.g. if a survey was used – how was the survey carried out, how was the target population determined, how many were surveyed and how they were surveyed (by interview or questionnaire).

Results

This is the main body of the report from which the author's ideas are developed. It should include the main findings in a logical and progressive manner interspersed with graphs to assist understanding. It should contain the requisite information to justify the conclusions and recommendations which follow.

Conclusions

These are derived from the results section and should also link back to the aims and objectives. No new information should be included. Bullet points are a recommended way for emphasising the key points.

Recommendations

This section highlights the actions which need to be taken to follow on from the project. As with the conclusion section, recommendations should be derived from the main body of the report and should not include new information.

Action Plan

All reports must include an action plan where recommendations have been made. It should include the action required, who has responsibility for doing it and the date it should be completed by, if necessary date and plan for re-audit.

References

All items referred to in a report should be appropriately referenced using the Harvard system.

Form R3 – Completed Audit Proforma

Directorate:			
Sub-specialty:			
Project Title:			
Project Supervisor: Please include name, phone, email, and location. (You may list others on the project, in which case please state who is the Supervisor.)			
Project Priority:	NICE <input type="checkbox"/> NSF <input type="checkbox"/> National Audit Programme <input type="checkbox"/> NCEPOD <input type="checkbox"/> Other Trust Priority <input type="checkbox"/> Other Directorate Priority <input type="checkbox"/> None of these <input type="checkbox"/>		
Please indicate which site this audit refers to: <i>(Click on a box to set or unset the options.)</i> Freeman <input type="checkbox"/> RVI <input type="checkbox"/> NGH <input type="checkbox"/> WGH <input type="checkbox"/> Dental Hospital <input type="checkbox"/> Centre for Life <input type="checkbox"/> Cross-site <input type="checkbox"/>			
Project Type?	Multi-disciplinary <input type="checkbox"/>	Uni-disciplinary <input type="checkbox"/>	
Disciplines:	Medical <input type="checkbox"/>	Nursing <input type="checkbox"/>	AHPs <input type="checkbox"/> Manager <input type="checkbox"/> Other <input type="checkbox"/>
Please name other groups:			
Cross organisational? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, specify: Other Acute <input type="checkbox"/> Community <input type="checkbox"/> Education <input type="checkbox"/> GP <input type="checkbox"/> Mental Health <input type="checkbox"/> Public Health <input type="checkbox"/> Social Services <input type="checkbox"/> Other (please specify below) <input type="checkbox"/>			
Did audit directly involve patients, carers or the public? <i>(i.e. recruiting their views)</i> Yes <input type="checkbox"/> No <input type="checkbox"/>			
Was Project:	First Audit? <input type="checkbox"/>	Re-audit? <input type="checkbox"/> →	Please provide, title and date of previous audit:
Title of evidence based criteria/standards: <i>(If NICE guidance please include number, e.g. TAG 104, IPG 153, etc.)</i>			
Source:	NICE <input type="checkbox"/>	NSF <input type="checkbox"/>	National guidelines <input type="checkbox"/> Local guidelines <input type="checkbox"/> Other <input type="checkbox"/>
Please indicate the method(s) used to collect the data: <i>(you can choose more than one option)</i>			
Questionnaire <input type="checkbox"/>	Case Note Review <input type="checkbox"/>	Interview <input type="checkbox"/>	Critical Incident Monitoring <input type="checkbox"/>
Focus Group(s) <input type="checkbox"/>	Patient diaries <input type="checkbox"/>	Observation <input type="checkbox"/>	Other (please specify below) <input type="checkbox"/>
Start Date: <i>(dd/mm/yyyy)</i>		Completion Date: <i>(dd/mm/yyyy)</i>	

1. Aims of the Project:

2. **Time period studied and sample size:**

3. **Main results/findings:**

(e.g. level of compliance with NICE guidance audit criteria.)

4. **Dissemination:** How did you share your findings? Report Presentation Publication

(Please state to whom presented and when, including any external bodies, and/or where published and when.)

5. **Recommendations:**

Type of Recommendation:	Description:
Changes to policies/guidelines/protocols	
Education awareness sessions	
Patient information	
Resources	
Service Provision	
Other	

6. **Does this require re-audit?** Yes No **If Yes when will it be re-audited?** *(dd/mm/yyyy)*

If Yes, who will be responsible for the re-audit? (NAME and JOB TITLE in BLOCK CAPITALS)	
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Your signature: _____ **Date:** *(dd/mm/yyyy)* _____
NAME: _____ **JOB TITLE:** _____
(in BLOCK CAPITALS) (in BLOCK CAPITALS)

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Clinical Audit Policy	Policy Author:	Steve Stoker, Clinical Effectiveness Manager
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:	No	This policy does not discriminate against any individual or group on the basis of race, ethnicity, nationality, gender, culture, religion, sexuality, age or disability.
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4(a).	Is the impact of the policy/guidance likely to be negative? (If “yes”, please answer sections 4(b) to 4(d)).	N/A	
4(b).	If so can the impact be avoided?	N/A	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
4(d).	Can we reduce the impact by taking different action?	N/A	

Comments:	Action Plan due (or Not Applicable): Not applicable
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Name and Designation of Person responsible for completion of this form:Steve Stoker, Clinical Effectiveness Manager..... Date:.....20 January 2010.....

Names & Designations of those involved in the impact assessment screening process: Clinical Effectiveness, Audit and Guidelines Committee.....

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)

For advice on answering the above questions please contact Helen Lamont, Director of Nursing, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) steven.stoker@nuth.nhs.uk together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.