This document is a valid document, however due to organisation change some references

Policy Number	SA39
Policy Name	Corporate Clinical Audit Policy
Policy Type	Trust-wide Non-clinical
Accountable Director	Executive Director of Nursing
Author	Head of Nursing
Recommending Committee	Clinical Audit and NICE Assurance Group
Approving Committee	Aqusition Steering Group
Date Originally Approved	March 2016 (July 2016)
Next Review Date	February 2019

to organisations, organisational structures and roles have now been superseded. The table below provides a list of the terminology used in this document and what it has been replaced with. When reading this document please take account of the terminology changes on this front cover

Terminology used in this Document	New terminology when reading this Document
Mersey Care NHS Trust	Mersey Care NHS Foundation Trust
Trust Board	Board of Directors

TRUST-WIDE NON-CLINICAL POLICY DOCUMENT

CORPORATE CLINICAL AUDIT POLICY

Policy Number:	**SA39**
Scope of this Document:	**All Staff**
Recommending Committee:	**Clinical Audit and NICE Assurance Group**
Approving Committee:	**Executive Committee**
Date Ratified:	**March 2016**
Next Review Date (by):	**February 2019**
Version Number:	**2016 – Version 5**
Lead Executive Director:	**Executive Director of Nursing**
Lead Author(s):	**Head of Nursing**

TRUST-WIDE NON-CLINICAL POLICY DOCUMENT

2016 – Version 5

Quality, recovery and wellbeing at the heart of everything we do

Mersey Care NHS

TRUST-WIDE NON-CLINICAL POLICY DOCUMENT

CORPORATE CLINICAL AUDIT POLICY

Further information about this document:

Document name	**CORPPORATE CLINICAL AUIT POLICY SA39**
Document summary	**The objective of this policy is to describe the framework for managing clinical audit and describes:-** • **The duties of all parties within Mersey Care NHS Trust** • **The development of the Clinical Audit Programme** • **The Clinical Audit process** • **The required contents of a Clinical Audit report** • **The process for monitoring compliance with the standards of the policy** **This policy will be made available in other formats such as easy read, audio, Braille, large text, other languages and different coloured paper on request.**
Author(s) Contact(s) for further information about this document	**Maria Tyson** **Head of Nursing** **Telephone: 0151 473 2871** **Email: maria.tyson@merseycare.nhs.uk**
Published by Copies of this document are available from the Author(s) and via the trust's website	**Mersey Care NHS Trust** **V7 Building** **Kings Business Park** **Prescot** **Merseyside** **L33 1PJ** **Your Space Extranet: http://nww.portal.merseycare.nhs.uk** **Trust's Website www.merseycare.nhs.uk**
To be read in conjunction with	Health Records Policy and Procedures IT06 Confidentiality and Information Sharing IT10
This document can be made available in a range of alternative formats including various languages, large print and braille etc	

Version Control:

		Version History:
Version 1	Approved by Medical Director	July2012
Version 2	Approved by Medical Director	October 2012
Version 3	Approved by Medical Director	February 2014
Consultation Draft Version 4	Policy Group Meeting	23.02.2016
Consultation Draft Version 4	Executive Committee	24.03.2016
Version 5	Acquisition Steering Group	June 2016

SUPPORTING STATEMENTS

this document should be read in conjunction
with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

Contents

1. PURPOSE AND RATIONALE

1.1 This Policy has been reviewed in line with the Healthcare Quality Improvement Partnership (HQIP) *Clinical audit: a guide for NHS boards and partners - summary* published in January 2015 to reflect the changes in the NHS in England, the Health and Social Care Bill, the lessons from Mid Staffordshire and Keogh Reviews and the enhanced focus on well led organisations.

1.2 Healthcare Quality Improvement Partnership (HQIP) is contracted by the Department of Health to deliver outcome focused quality improvement programmes structures around collection of clinical data, and advocate that a clinical audit policy should describe a working definition of clinical audit and how the organisation practices clinical audit, its systems and its processes.

1.3 This Policy focuses on the developing role of quality improvement, audit and review in providing assurance by clinicians to the board, stakeholders and commissioners that services are well led, delivering responsive improved cost effective outcomes with transparency in choice of audit, action plans and impact.

1.4 Participation in national clinical audits and publication of outcome statistics is now required as part of the NHS England Standard Contract and CQC guidance.

1.5 Clinical audit is a tool in strategic management as part of the broader quality improvement programme; which provides assurance and is aligned to broader interests and targets that the board needs to address.

1.6 Clinical audit is part of an overall framework of quality and is reported in the Trust's Quality Account. The Trust is regulated and performance managed against its participation in clinical audit.

1.7 This policy sets out the Quality Improvement Audit Framework which identifies six key areas of focus for clinical audit:

- Audit of Fundamental Standards
- Audit of Perfect Care, Quality Account priorities and Local CQUIN
- Audit of Divisional priorities
- Participation in National Accreditation Schemes
- Participation in National Audits
- Clinician and student audits to support divisional priorities

1.8 The purpose of clinical audit is improvement. The trust operates a trust-wide rolling audit programme, which covers all stages of the audit cycle, but allows prioritisation and stakeholder involvement in-year. Audits are considered complete when there has been re-audit and reported improvement.

2. OUTCOME FOCUSED AIMS AND OBJECTIVES

2.1 The quality improvement and clinical audit programme is aligned to the broader strategic interests of the organisation and other aspects of our strategic management. Clinical audit can provide assurance to commissioners and the trust and any gaps identified can be addressed in forthcoming plans and budgets.

2.2 Within our broader quality improvement and clinical audit programme, there is a robust process for ensuring that each quality improvement method is chosen for its

merit and impact. Clinical audit is utilised when it has been identified as the most effective tool to improve and assure the quality of the service delivered.

2.3 A delegated sub-committee of the board the Quality Assurance Committee assures that audits and re-audits are completed. Where there is a lack of assurance the committee identifies and reviews action plans and may escalate concerns to the Audit Committee.

2.4 By adopting a professional approach to clinical audit by setting auditable procedures for, selecting and delivering audit-based improvement the board can determine materiality (risk, value and return) and trigger points for escalation as well as benchmarking to compare with norms and emerging better practice.

2.5 The trust's quality improvement programme is focused on the patient pathway, and working in partnership with other health and social care providers and commissioners involved in these pathways, has proven to improve overall care in our community. We invite external organisations to peer- review our approach.

3. SCOPE

3.1 Every employee within Mersey Care NHS Trust has a responsibility for participating in Clinical Audit and quality improvement initiatives.

3.2 This policy applies equally to all members of staff, either permanent or temporary.

4. DEFINITIONS

4.1 Clinical Audit is 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.

4.2 Clinical audit involves measuring clinical practice against predetermined standards of best practice. Standards are an agreed statement of best practice which will improve the quality of care, they will usually be broken down into measurable criteria with an expected level of compliance Criteria are explicit statements that define what is being measured and represent elements of care that can be measured objectively.

(e.g. 100% of records will contain the service user's/patient's date of birth).

4.3 Standards should be evidenced based and ideally taken or adapted from sources including national guidance recommendations e.g. NICE, clinical audit criteria, network or local guidelines and policies.

5. DUTIES

5.1 Executive Director of Nursing

5.1.1 The Executive Director of Nursing holds organisational accountability for Clinical Audit and has responsibility for Clinical Audit at Trust Board level; and it's sub-committees; in particular the Quality Assurance Committee.

5.2 **Head of Nursing**

5.2.1 The Head of Nursing is responsible for relaying information, including any concerns, in relation to Clinical Audit activity to the attention of the Executive Director of Nursing, and any sub-committees of the Board on behalf of the Executive Director of Nursing.

5.3 **Clinical Audit Co-ordinator**

5.3.1 The Clinical Audit Co-ordinator, under the direction of the Executive Director of Nursing, is responsible for Clinical Audit within the Trust. The Clinical Audit Co-ordinator informs the Executive Director of Nursing, or another nominated deputy appointed by the Executive Director of Nursing, including the Head of Nursing, of all Clinical Audit activity through the Quality Assurance committee.

5.4 **Clinical Divisions**

5.4.1 Each Clinical Division has a responsibility to prioritise areas to be audited and oversee local Clinical Audit activity as part of the relevant Governance framework.

5.5 **Clinical Audit & Effectiveness Team**

5.5.1 The Clinical Audit & Effectiveness Team, under the direction of the Clinical Audit Co-ordinator, is responsible for conducting or liaising with other professionals to coordinate Trust-wide audits.

5.6 **All Staff**

5.6.1 All staff have a responsibility to support the clinical audit process, inclusive of communicating and acting upon findings and recommendations from audit reports.

6. PROCESS

6.1 In pursuit of the promotion of a culture of learning and continuous service improvement that delivers demonstrable improvements in care and contributes to meeting the trust's corporate objectives alongside clinical audit, there are various other data collection and quality monitoring activities and audit included in the Quality Improvement and Audit programme.

6.2 **Patient experience survey**

6.2.1 The trust is committed to providing the best possible experience for everyone who comes into contact with the Trust. To support the delivery of this it is essential to measure, evaluate and improve services influenced by patient experience

6.2.2 Patient experience and is not just about the care received but how we communicate, how our environments impact on the service delivery and experience and is essential to ensure that services are developed and improved as a result of patient opinions and feedback. Service users and carers need to see evidence that their views have been listened to. It is essential that information gathered and lessons learned are reported through governance arrangements to ensure that they affect change.

6.2.3 Technology is used to support patient experience with the use of ipads and this has been well received by service users. This has enabled speedy access to the results

with instant download capability and access to the data through “Share point” and accessed through the BiT (Business Intelligence Today). The reports are available at ward/team level by theme or specific question. Analysis can act as an early warning indicator, influence service improvements and prompt a rapid response when required or identify areas high performance, significant improvement or the impact of service change or redesign.

6.2.4 The results are accessible in real time with instant reporting as a result of the use of technology and systems built to support the process.

6.2.5 The results are reported monthly enabling services to highlight areas for quality improvement and provide evidence of any improvements or impact of service change. The Trust Board receives quarterly reports as part of the Governance of Quality Report and the results are also analyzed at the weekly Quality Surveillance meetings where the data is linked with other data sources and local intelligence

6.3 **Audit of CQC Fundamental /Regulatory Standards**

6.3.1 **Five Domains Self assessment standards**.

6.3.2 A set of standards have been developed within the trust based on the CQC five domains of safe, effective, caring responsive and well led and the fundamental standards of:

- Person-centred care
- Dignity and respect
- Need for consent
- Safe care and treatment
- Safeguarding service users from abuse
- Meeting nutritional needs
- Cleanliness, safety and suitability of premises and equipment
- Receiving and acting on complaints
- Good governance
- Staffing
- Fit and proper persons employed
- Fit and proper person requirement for directors
- Duty of candour

6.3.3 Team managers are required to self-assess their team performance against the standards on a monthly basis. Using a RAG rating Red, Amber, and Green against specific criteria within each standard. This is uploaded in the trust’s Five Domains of Quality SharePoint site and ratings are used as indicators of quality and safety and are monitored via the trust surveillance meetings.

6.4 **Quality Review visits.**

6.4.1 An annual programme of visits to all wards/community based teams is drawn up. The visit by a team of clinicians and departmental staff and may include board members takes place on site and involves observation in practice direct contact with ward/team staff, service users and carers if available and quality assessing clinical records and

team procedures and communication.

6.4.2 The visit incorporates annual audits and statutory and regulatory requirements including Health and Safety, infection control and Mental Health Act compliance and clinical audit with a focus on the CQC fundamental standards and five domains of safety, effectiveness, responsiveness, caring and well led.

6.4.3 Individual reports are uploaded into SharePoint and a team action plan is generated for areas of improvement within the SharePoint site. The results are also discussed at the weekly Quality Surveillance meetings where the data is linked with other data sources and local intelligence.

6.4.4 The thematic results are reported bi- monthly to the Quality Assurance Committee as part of the Integrated Governance of Quality Report which highlight areas for quality improvements and provide evidence of any improvements or impact of service change.

6.5 **Duty of candour** audit of moderate harm and above

6.5.1 There is a requirement to report on all incidents where Duty of Candour applies and to identify any key themes or level of issues within services. A Quarterly report from DATIX is drawn up and shared at the quality surveillance meetings and Divisional Governance Boards. Service Leads are responsible for any action plans required.

6.6 **Quality Account priorities**

6.6.1 There is a legal requirement to publish an annual 'Quality Account' which provides the public with an overview of the quality of care provided by the Trust, the document is uploaded onto NHS Choices website for ease of access. The Quality Account includes the Centre for Perfect Care and Wellbeing priorities a summary of clinical audit activity to improve the quality of patient care across the Trust's services. Delivery of the Quality Account is monitored by the Quality Assurance Committee

6.7 **Working with Commissioners**

6.7.1 The trust is committed to performing clinical audit as part of the Community Quality Innovation (CQUIN) projects within the organisation. Performance and Information and Finance Departments with the Clinical Divisions and commissioners agree areas for clinical audit in quarter four for inclusion in the annual Clinical audit programme of activity commencing on 1st April to 31st March each year.

6.8 **National clinical audit**

6.8.1 The programme is developed following national guidance published by the Healthcare Quality Improvement Partnership (HQIP) and considers National Clinical Audits which are listed in the National Clinical Audit Patients Outcome Programme (NCAPOP) and are considered relevant to Mersey Care.

6.9 **Participation in National Accreditation Schemes**

6.9.1 The value of accreditation as external assurance and assessment of the independence of internal audit is becoming more significant according to HQIP

(2015) and can raise the profile of the organisation. The Medical Director and Finance Director support the Accreditation process and acute wards for adults, older people, learning disability, psychiatric intensive care and triage wards for working age adults along with ECT services, memory services (MSNAP),psychiatric liaison service (PLAN) and Forensic Quality Network for forensic mental health services are supported to attain accreditation.

6.10 **Clinical Records audit**

6.10.1 Audit of clinical record entries completed by multi-disciplinary professionals reviewing quality and standards of record entries required as mandatory annual evidence to support the Trust Information Governance Toolkit standards

6.10.2 This audit considers requirements specified within Corporate Health Records Policy & Procedures IT06 and the Information Governance Toolkit Standard 404.

6.10.3 The Information Governance Requirement Assurance 404 specifies that;

6.10.4 "It is essential that organisations undertake audits of clinical records in all specialties to ensure that the quality of the health record can justify any decisions taken if required." this audit is reported on an annual basis to the Trust's Health Records Committee and actions to enable improvements are agreed and included in an action plan.

6.11 **Director of Nursing Audit priorities**

6.11.1 Priorities reflective of organisational objectives for clinical audit as outlined in the quality Account and Quality Schedule agreed by commissioners and priority areas that meet statutory requirements.

6.11.2 The trust acknowledges the significance of clinical audit as a quality improvement process and as an important mechanism for providing assurance in relation to the provision of safe and effective care. The trust is therefore committed to delivering clinical audit in the clinical services it provides.

6.12 **Clinical Audit Programme Development**

6.12.1 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, but must be owned by clinical services.

6.12.2 The proposed programme will be prepared by the Clinical Audit Coordinator following consultation with the relevant stakeholders, the Division's will present their clinical audit priorities and plan to the respective Governance Board for approval, the overall clinical audit programme will be presented to the Quality Assurance Committee and will include national clinical audits and confidential enquiries that are considered relevant to the Trust and clinical audits of relevant national guidelines including NICE. In addition, clinical audit topics that align with Trust priorities or have been identified as clinical governance priorities will be included.

6.12.3 National Clinical Audit of Patient Outcome Programme (NCAPOP) and other national clinical audits and confidential enquiries which are relevant to the services provided and where participation must be reported on in Quality Account

6.12.4 Audits demonstrating compliance with regulatory requirements e.g. audits with the

aim of providing evidence of implementation of NICE guidance, and other national guidance such as that coming from the Clinical Outcomes Review Programme (formerly National Confidential Enquiries)

6.12.4 Audits required by external accreditation schemes

6.12.5 Audits which must be undertaken in order to comply with Trust policies which are themselves subject to external review

6.12.6 Commissioner priorities including national and regional CQUINS audits.

6.13 **Clinical Audit Proposals**

6.13.1 Any staff member planning to undertake a Clinical Audit should complete a Project Proposal Form (Appendix One). The audit will be logged on the trust database. A timetable for each clinical audit project will be completed by the Clinical Audit Coordinator and progress or slippage reported through the Quality Assurance Committee. All clinical audits undertaken within the Trust must complete the audit cycle inclusive of re-audit where appropriate. Each audit on the Trust clinical audit programme will have an identified member/s of staff to coordinate the audit.

6.14 **Sampling and Data Sourcing**

- **Sampling:** The sample chosen for Clinical Audits must be sufficient to produce credible results. For small populations a representative sample may be determined by the professionals coordinating the audit and selected randomly. For large populations a representative sample should be determined using an electronic sampling technique.

- **Data Sourcing:** Data collected for audits should be from a reliable source.

6.15 **Data Collection and Analysis**

- **Data collection tools:** Data collection tools must include a unique identification number, which refers to the subject audited, the date which data was collected; and it is recommended that the name of the auditor is included on the data collection tool, especially where more than one auditor is collecting the data. The Clinical audit coordinator can advise and assist with developing audit tools.

- **Data analysis:** This is the process of extracting relevant data from that collected and interpreting into useful information. The clinical audit department will facilitate this. Analysis can be illustrated diagrammatically; i.e. using charts, as percentages, or using more sophisticated techniques; although these are not normally necessary for Clinical Audit purposes.

- **Root cause analysis:** Where the results of a clinical audit indicate sub-optimal practice and there is scope for improvement, a root cause analysis approach is undertaken to identify what improvements are needed.

6.16 **Clinical Audit Report**

6.16.1 A Clinical Audit report allows the auditor to share all aspects of the Clinical Audit with their audience. A Clinical Audit report must include the following; and it is

recommended that these are used as section headings:

- **Introduction:** A background of the audit, including the relevance of the audit and any current government policy and other key documentation.

- **Aim:** A definition of the key purposes of the audit.

- **Objectives:** What the audit is trying to achieve, taken from policy / requirements; i.e. the audit standards.

- **Methodology:** An explanation of the criteria for inclusion in the audit, the total population and the sample selected, and the method of data collection.

- **Findings:** A detailed description of the audit findings numerically and/or pictorially. An overall comparison of the results for each service / clinical business unit, highlighting the level of compliance against each of the objectives.

- **Conclusion:** It is recommended to provide your audience with a brief overview of your audit results.

- **Action for improvement:** Clinical Audits will highlight issue which should be considered for improvement. Actions for improvement should be discussed and agreed prior to the development and sharing of an Action Plan.

6.16.2 Clinical Audit Leads and specialty staff are responsible for ensuring the identified actions are incorporated into clinical practice and relevant business plans. Services or departments are responsible for the implementation and monitoring of action plans.

- **Re-Audit:** Re- audit is important to determine whether agreed actions have been implemented according to the action plan. The Clinical Audit Department will support forward planning of re-audits, when timescales have been given. Clinical Audit projects due for re-audit will be considered during the planning of the annual clinical audit programme. Where appropriate, re-audit may focus on specific aspects that require improvement (i.e. not a full re-audit).

6.17 **Information Governance**

6.17.1 All clinical audit activity must take account of the Data Protection Act (1998), the Caldicott Principles (1997 & 2013) and the Trust Confidentiality Policy IT10. This means that's data should be:

- adequate, relevant and not excessive
- accurate
- process for limited purpose
- held securely
- not kept for longer than is necessary
- audit data held electronically should be stored on server according to the Trust Retention and Destruction Schedule
- shared appropriately and safety in the best interests of their patients

6.17.2 Clinical audit activity must conform to the requirements of the NHS Confidentiality Code of Practice (2003) which states the 'Patients must be made aware that the information they give may be recorded, may be shared I order to provide them with care, and may be used to support local clinical audit'. If patients have been informed,

Section 60 of the Health and Social Care Act 2001 makes provision for the collection of patient identifiable data for the purpose of clinical audit; however best practice directs that data be anonymised unless there was a compelling reason not to do so.

7. CONSULTATION

7.1 This policy has been reviewed and updated in consultation with Divisional Audit Leads, Head of Nursing and the Executive Director of Nursing.

7.2 The Quality Assurance Committee and Audit Committee agree the audit programme for the coming year and provide bi monthly updates.

8. TRAINING AND SUPPORT

8.1 Clinical audit training is included in the trust's trainee doctor 's induction and is provided by the Clinical Audit Coordinator, support and training and guidance is also provided on request to staff audit leads in respect of audit design, sample size, audit tool development and root cause analysis.

9. MONITORING

9.1 The Clinical Audit Coordinator will ensure that all clinical audit projects comply with this policy. Projects that do not comply will not be approved.

9.2 All approved clinical audit projects are required to submit clinical audit reports and action plans to the Divisions governance meetings these will also be uploaded to the Clinical Audit SharePoint site and data base. The Clinical Audit Department will monitor the progress on the implementation of action plans and ensure re-audits where required. Progress will be reported bi-monthly to the Quality Assurance Committee.

9.3 The Clinical Audit Coordinator will produce regular updates and an Annual Clinical Audit Report for presentation to the Quality Assurance Committee and bi-annual reports to Local Commissioners as required by the Quality schedules.

9.4 The Annual Report will also be included in the Trust's Annual Quality Account.

10. SUPPORTING DOCUMENTS

Caldicott Committee, The. (1997 & 2013). Report on the review of patient-identifiable information. London: Department of Health.
Available at: www.oxfordradcliffe.net

Confidentiality and Information Sharing IT10

Data Protection Act 1998. London: The Stationery Office.
Available at: www.opsi.gov.uk

Health Records Policy and Procedures IT06

Health and Social Care Act 2012

Health Quality Improvement Partnership (HQIP). (2015) Clinical audit: a guide for NHS boards and partners Summary.
Available at: www.hqip.org.uk

Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report, Professor Sir Bruce Keogh KBE (July 2013).
Available at: http://www.nhs.uk/nhsengland/bruce-keogh-review/documents/outcomes/keogh-review-final-report.pdf

Mid Staffordshire NHS Foundation Trust Inquiry (Francis Report, 2010 & 2013)

National Health Service Litigation Authority (2011) Risk Management Standards. January

.

National Institute for Health and Clinical Excellence (NICE) (2002) Principles for Best Practice in Clinical Audit. Oxon: Radcliffe Medical Press.
Available at: www.nice.org.uk

The NHS Litigation Authority (NHSLA) standard for clinical audit (Standard 2.1)

11. APPENDICES

Appendix 1

AUDIT PROPOSAL

INTRODUCTION

I would like to propose this Audit for consideration. I understand that the Clinical Audit and Effectiveness Team and the relevant service clinical audit lead will consider the proposal and that I will be informed of the outcome within 7 working days of submission unless extraordinary circumstances prevail.

TITLE:

LEAD (name and contact details):

DIVISION:

DATE:

SUMMARY OF PROPOSAL (no longer than half a page):

THE AUDIT

STATEMENT OF THE ISSUE

(Why? – a brief description of the issue, the relevance and importance of dealing with the issue to you, your service, and the Trust)

AIMS & OBJECTIVES

(What? – a description of the key themes the audit will focus on, including any standards you intend to monitor against and the impact the outcomes of the audit will have upon the whole organisation)

METHODOLOGY

(How? – a description of how you intend to tackle the issue; i.e. sample size, your chosen approach to the audit and how any learning from the audit will be applied across the whole organisation)

TIME MANAGEMENT

(When? – a description of how the audit will be managed, including the timeframe and any milestones)

ENGAGEMENT & INVOLVEMENT

(Who? – details of who will be involved in the audit and their specific roles, including any actions for improvement)

a) **Who to disseminate audit findings to?**
b) **Who is responsible for Action Planning?**

Clinical Audit Action Plan 2015/16

Audit Title and Date:
Audit Lead:
Background Information

Actions	Next steps	Person(s) Responsible	Time Frame
1.			
2.			
3.			
4.			

Please Return to:
Colette Hollis, Clinical Audit Co-ordinator,
Clinical Audit & Effectiveness Department, 2nd Floor, V7 Building, Kings Business Park, L34 1PJ
E-mail: Colette.Hollis@merseycare.nhs.uk Telephone: 0151 473 2841 / 07977077602

Equality and Human Rights Analysis

Title: Corporate Clinical Audit Policy
Area covered: Trust wide

What are the intended outcomes of this work? The policy set out a framework for clinical audit and quality improvement programme.
Who will be affected? Staff and service users.

Evidence
What evidence have you considered? The Policy
Disability (including learning disability) No issues identified.
Sex No issues identified.
Race No issues identified.
Age No issues identified.

Gender reassignment (including transgender) No issues identified.
Sexual orientation No issues identified.
Religion or belief No issues identified.
Pregnancy and maternity No issues identified.
Carers No issues identified.
Other identified No issues identified.
Cross Cutting No issues identified.

Human Rights	**Is there an impact?** **How this right could be protected?**
Right to life (Article 2)	Not engaged
Right of freedom from inhuman and degrading treatment (Article 3)	Not engaged
Right to liberty (Article 5)	Not engaged
Right to a fair trial (Article 6)	Not engaged

Right to private and family life (Article 8)	The policy is protected of confidential personal data.
Right of freedom of religion or belief (Article 9)	Not engaged
Right to freedom of expression Note: this does not include insulting language such as racism (Article 10)	Not engaged
Right freedom from discrimination (Article 14)	Not engaged

Engagement and Involvement
This policy has been reviewed and updated in consultation with Divisional Audit Leads, Head of Nursing and the Executive Director of Nursing.

Summary of Analysis

Eliminate discrimination, harassment and victimisation
No negative impact has been noted.

Advance equality of opportunity
The policy is supportive to staff undertaking audit as training and support is provided on an individual basis.

Promote good relations between groups
Nothing indicated within policy.

What is the overall impact?
The policy is not noted to be discriminatory directly of indirectly.

Addressing the impact on equalities

Action planning for improvement

For the record
Name of persons who carried out this assessment:
Maria Tyson, Head of Nursing
Julie Matthews, Personal Assistant

Date assessment completed:
17th March 2016

Name of responsible Director: Ray Walker, Executive Director of Nursing
Date assessment was signed: 17th March 2016