



HQIP

Healthcare Quality
Improvement Partnership

Guide to Facilitating Clinical Audit across Different Care Settings

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Clinical audit tool to promote quality for better health services

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1 Introduction

1.1 Who this guide is for

This guide is intended for anyone considering whether to use an interface audit to drive quality improvement. It is aimed at clinical audit managers and staff, but also will benefit interested clinicians and social care providers who want to use interface audit to improve the quality of patient care.

The guide aims to help people carry out interface clinical audits, including to:

- choose a suitable subject for interface audit
- gain approval and positive support for the audit and for change needed as a result of the findings
- establish a steering group for the audit that will make decisions about the audit, and will include clinical audit staff, clinicians, social care providers if relevant, and patients
- ensure that appropriate provisions for data protection and for information sharing are in place for an interface audit
- work through the stages of carrying out an interface audit.

Only through implementing changes that clearly benefit patients will interface audit be useful. Actions taken through interface audit can be achieved and can make a positive impact on patient care. However, it requires real commitment and hard work to get these results.

Also see *Guide to Carrying out Clinical Audits on the Implementation of Care Pathways* at www.hqip.org.uk.

1.2 The context

When patients need care, they often are not aware that different organisations are responsible for providing their care. They may be genuinely surprised when they learn that two or three separate organisations are involved. Patients visit their general practitioners and may be referred to a local hospital for an outpatient appointment. They can be admitted to the hospital and then need care following discharge. Post-discharge care can be provided by social services, for example, a carer, and by a primary care trust that may provide district nursing visits. In total, three or four organisations may share responsibility for a single patient's care.

The treatment of even a simple patient condition with simply defined care requires communication and cooperation among staff members working in several large organisations. Failure to communicate about any part of the care can leave a patient compromised and unsafe, and can mean that optimum care is not provided. Staff members who provide a patient's care can be unaware of what happens at the 'interfaces' of care and that problems in delivering care happen, until a patient tells a member of staff about the patient's experience getting care.

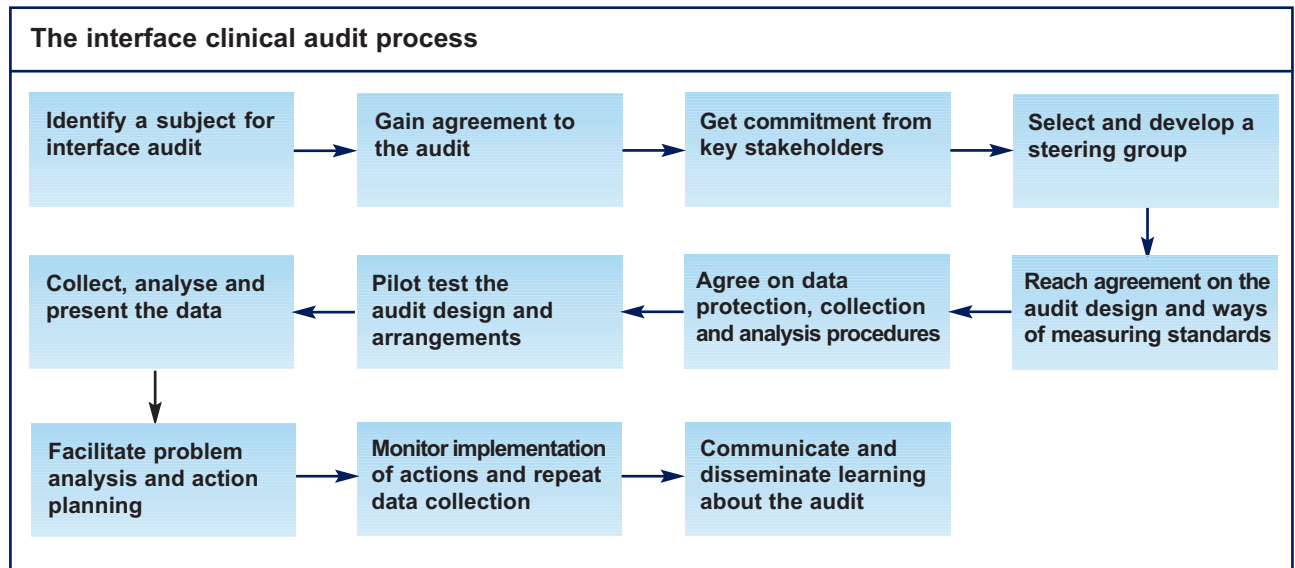
1.3 Interface audit

An interface clinical audit is a clinical audit that is carried out by healthcare professionals in different healthcare organisations working as a team to measure and improve the quality of patient care.¹ An interface clinical audit follows the same overall process as any clinical audit.

It includes all of the following:

- clearly stated objectives and a robust design
- well-defined standards of good practice
- accurate collection of data on care or service in comparison with standards
- analysis and evaluation of the findings
- implementation of any changes in practice needed
- repeat data collection following the actions taken to determine if needed improvement has been achieved.

The process for arranging for and carrying out an interface audit is in the diagram.



Most interface audits have involved acute and primary care settings. However, interface audits can involve any combination of two or more organisations. For example, a primary care trust (PCT), a hospital and a hospice could carry out a clinical audit on end-of-life care; a PCT, a mental health organisation and social care providers could be involved in an interface audit on discharge planning; or a hospital and an ambulance service could work together to audit turnaround times.

1.4 What's involved in setting up an interface audit

Successful interface audit has key requirements at the start as summarised in the box.

Key requirements for successful interface audit	
An important idea for clinical audit that involves another organisation	Organisations are unlikely to make the time available to work on an interface audit if the significance of the subject of the clinical audit is not clear at the start, as well as the possibility of improving the quality of care for patients across the organisations involved.
Involvement of all the organisations responsible for care	One organisation may be more interested in the audit than the others and that organisation may need to: <ul style="list-style-type: none"> • ensure that all other organisations are involved • persuade the other organisation(s) to make a commitment to the audit and dedicate resources to support it.

Key requirements for successful interface audit

Clear communication channels among the organisations involved	Success in designing and carrying out the audit, including achieving improvements in care, will depend on having established and effective channels of communication among the organisations involved in the audit.
Leadership for the work involved in carrying out the clinical audit	At least one clinician who is enthusiastic, knowledgeable about the clinical audit process and the care involved in the subject, and has leadership skills is essential to drive the process of gaining support for and carrying out the clinical audit.
A steering group for the audit with members from all organisations involved	Representatives of all organisations involved, including voluntary services, should be invited to participate at the start in steering group meetings in order to use their experiences of patients and their needs to influence the positive direction for the audit.
Knowledge by the team involved of the parts of the care process and part of the process where care can be compromised	The team carrying out the audit will need to gain and share knowledge about how the relevant care is delivered now and parts of care that can be suboptimal. The team can: <ul style="list-style-type: none">• map the care processes to identify all the key stages and steps in delivering care• involve patients and staff members who deliver the care to learn about the care process from their perspectives.
Agreement by all concerned to data protection requirements and to having information sharing protocols in place between the organisations involved	Everyone involved in the audit has to have the capacity to support confidentiality and anonymity requirements that will need to be in place as the audit is carried out. Information sharing protocols will need to be in place between all participating organisations before the audit can be carried out.
A well-designed clinical audit and robust data collection protocol and process	Success in carrying out an interface audit will depend heavily on everyone involved having a complete and correct understanding of the clinical audit process and contributing to a well-designed audit and data collection processes that will produce valid and highly reliable data.

2 How to get agreement on a clinical audit to be carried out across organisations

A clinical audit manager or an individual clinician often carries out the initial work involved in selecting a subject for interface audit. You can gather ideas for clinical audits across organisations from a variety of sources as listed in the box on the next page.

Try to get information from all local organisations involved related to possible interface audit subjects to see if information sources match. If all the organisations have essentially the same information to drive a decision to carry out the audit, you have a powerful basis for working together and combining resources to support the audit. In addition, every organisation has a real incentive for improvement.

Sources of ideas for an interface audit

Government or organisational priority for improvement of a service that involves the organisations

A subject that is causing a lot of 'noise in the system' as reported by staff or patients, or through complaints, comment cards or patient surveys

A patient safety concern

A serious untoward incident that crosses organisational boundaries

Ideas from healthcare organisations' staff members working in Complaints Departments, Patient Advice Liaison Services (PALS) or Patient and Public Engagement (PPE) offices, or staff responsible for taking action on national patient surveys

Problems learned from NHS or other organisations' experiences

Reports on patients' experiences with services provided by the organisations

Integrated care pathways (ICPs) that involve the organisations. See *Guide to Carrying Out Clinical Audits on the Implementation of Care Pathways* at www.hqip.org.uk.

3 How to get commitment from key stakeholders to the clinical audit

3.1 Gaining agreement on the need to carry out the audit

Spend time gaining agreement to the clinical audit among clinical staff, including doctors, nurses or other healthcare or other professionals who are involved in the audit subject, and senior management staff in the organisations involved. Key stakeholders need to reach agreement that the audit subject is acceptable and worth the resources that will be required.

3.1.1 Leadership to build consensus

An enthusiastic clinician, who has the leadership skills to engage his or her peers in the audit and who fully understands the clinical audit process, can act as the catalyst gaining support and involvement among organisations. The lead clinician can start by informally discussing the idea of the audit with colleagues in the organisations involved, using data available about the subject of the clinical audit.

Alternatively, a clinical audit manager who has the support of clinical staff and networks that extend across the other organisations can ensure that there is approval to proceed with the clinical audit subject. Time spent in groundwork with clinicians and senior staff across the organisations involved is essential to success at this initial stage. Without organisational enthusiasm for the audit at the start, the audit may not get under way.

3.1.2 Patient input to influence consensus

Data from the national patient survey programme and patient comments provided by the survey, combined with actual words of complainants, issues raised to PALS staff or comment cards are invaluable in giving triangulated information about how a clinical service is provided. Use words provided by patients to:

- show the need for interface audit
- help to decide on the standards later in the audit process
- show the effectiveness of change later in the process, if further surveys and later complaints analysis indicate that the problems patients experience are resolved.

You also can use interviews with individual patients or one or more focus groups with patients to further explore issues related to the subject of the audit, and clarify the areas of practice that need to be measured. Patients invited to attend a focus group should be provided with a clear explanation of the desired outcome of the group and how the information they provide will be used by the organisations involved, for example, to formulate or agree on standards of care to be used as the basis for the interface audit. PPE staff working in the organisations involved could carry out the focus groups, which could facilitate closer collaboration and understanding of the need for the interface audit among the organisations. See *Patient and Public Engagement (PPE), PPE in Clinical Audit 2009* at www.hqip.org.uk.

3.2 Interface clinical audit project document

Develop a brief interface clinical audit project document to use as a basis for discussion with key stakeholders. The document should include:

- reasons why this subject should be chosen for an interface audit (for example, national priority, local priority or hot spot for complaints)
- the organisations that need to be involved (with the provision that more may be asked later by the steering group for the audit)
- potential benefits to the organisations (improved quality of care, reduced costs due to rationalisation of care or reduction of complaints)
- mechanisms that will ensure confidentiality of patient information and organisationally sensitive information
- assurance that one or more Caldicott Guardians will be involved in approving arrangements for data collection and analysis for the audit if needed.

Use the brief document describing the purposes of carrying out the interface audit later to develop the complete proposal and protocol for the clinical audit for formal approval by all the organisations involved.

An example of an interface audit on the care provided to people who deliberately self-harm

Background

People who self-harm once are statistically much more likely to repeat and to go on to commit suicide. People who display self-harming behaviour report that they are not treated well in Emergency Departments and perceive lack of respect and consideration of their dignity. Complaints and reports to PALS reflect these experiences. The Royal College of Psychiatrists has standards for caring for people who self-harm to ensure that these people who self-harm are properly assessed and followed up.

An example of an interface audit on the care provided to people who deliberately self-harm

Organisations to be involved

- ... Hospitals NHS Foundation Trust (for emergency care)
- ... Primary Care Trust (for notification to GPs)
- ... Mental Health Trust (for patients' perception of care and CPN referral)

Potential benefits to the organisations and to patients

The organisations want to ensure that they treat this patient group with respect and dignity and that they assess and follow up these patients properly, preventing further self-harm if at all possible. The benefits of the audit are intended to include:

- reduced attendances at the Emergency Department by people who self-harm
- reduced complaints by patients and their representatives about the care they receive
- increased appropriateness of referral and management of people who self-harm
- patients feeling treated with dignity and respect and, with proper follow up and information, may not self-harm in the future
- improved staff attitude toward people who self-harm through better understanding of their needs.

Confidentiality provisions

Data collected for the clinical audit shall be anonymous. A list will be made of the names and NHS numbers of patients to be included in the audit. A random number will be assigned to each patient on the list. The list of patient names, NHS numbers and random numbers assigned will be held in a secure file. Each data collection form used in the audit will contain only the random number assigned to a patient and never the actual name or NHS number.

If information about any patient is accidentally revealed, the patient involved will be officially informed in writing by the organisation involved of the circumstances in which the patient's name was revealed.

3.3 Gaining commitment from boards

Identify the most appropriate executive director in each organisation, whether it is the chief executive, the director of operations, the medical director or the director of nursing, to support the interface audit. Whichever director is selected, he or she must have the authority to ensure change is carried out in accordance with the findings of the audit.

The information provided to the relevant executive director should include the following points:

- the process for designing and carrying out the clinical audit through the steering group, which will include patients
- clinical staff members in the organisation who would be appropriate for inclusion in the steering group
- whether or not the executive director could attend the first meeting of the steering group to state the organisation's commitment to the audit
- alternatively, if the executive director could meet with one of the staff members who will be representing the organisation on the steering group and brief the staff member on the organisation's commitment to support the audit and the findings

- how the executive director would prefer to be kept informed about progress on the audit, for example, through getting a copy of minutes of steering group meetings, informal telephone calls if any help or encouragement is required, or just receiving the report of the clinical audit
- any concerns about the audit expressed by the director, including the mechanisms for working with other organisations and the sharing of data among the organisations involved.

3.3.1 A culture of trust

Trust and an agreement to information governance and confidentiality principles applied to the audit experience are essential for an interface audit. Clinicians need to feel safe to discuss their concerns across organisations without the threat that these concerns could be shared inappropriately or prematurely with others. Reassurance that senior management teams and boards of the organisations involved will be supportive of actions, as needed, should be an incentive to clinicians to participate or at least to give their positive support in the interface audit process.

4 How to select and develop members of the interface audit steering group

4.1 Composition of the steering group

Ensure that the steering group for the interface clinical audit includes representatives of services involved in all steps of the patient pathway for the subject of the audit and patients. Suggested roles for each group represented on the steering group are in the box.

Roles of representatives on the interface clinical audit steering group	
Multidisciplinary team members	Engage in the development of the audit, agree on the standards that are expected to be met, and facilitate changes in practice among themselves and their colleagues, should improvement be needed
Clinical audit staff	Advise the group on the design of the audit, the standards to be used, the data collection tool and protocol, data analysis, analysis of the findings of the audit and facilitation of discussion on actions needed; write interim and final reports; and agree on confidentiality and anonymity provisions for the audit
Patients	<p>Give a clear account of their journeys through the healthcare system and the experiences of any other patients with whom they have discussed their experiences</p> <p>Ensure that patients will be comfortable participating in the group. If not, facilitate one-to-one meetings with patients to learn about their experiences and issues, and take points patients make to steering group meetings on their behalf.</p>
Managers	Participate in order to understand the clinical audit process and to make the changes in working practice, providing organisational authority for the audit process, if required

Ask all organisations to suggest the names of people who could be involved in the steering group. With the agreement of each organisation’s appropriate executive director, the clinical lead or the clinical audit lead for the audit should approach these individuals to confirm their interest as well as consider the optimal number and composition of clinical team representation on the steering group.

Limit the number of clinical team members in order to get the work done speedily. For example, one physiotherapist could participate in the steering group to represent input from the profession, rather than having one physiotherapist from each organisation. Clinicians whose jobs cross over organisations are especially useful as they can represent more than one organisation.

Balance among professions in the steering group is extremely important. If one organisation has fewer members participating, the organisation’s management may decide that fewer resources from the organisation need to be contributed to support the audit or that the audit will not have impact on the organisation.

Find patients to participate in the steering group through any of the following methods:

- suggestions by the organisations’ PPE leads
- recommendations by clinicians for people who are suitable to be involved
- former complainants who are willing to participate.

Patients selected need to have experience of the condition that is the subject of the audit and preferably be trained by PPE staff on what will be expected of them and how they will be expected to contribute as members of the steering group. Patients that are not suggested by local PPE leads should be invited to attend training by PPE staff to prepare for actively participating in steering group meetings.

4.2 Anticipating the number of steering group meetings

The number of meetings of a steering group for an interface audit can vary, depending on the time that can be allocated to each meeting and the availability of the steering group members. A guide for meetings is in the box.

Guide for steering group meetings for an interface clinical audit	
Meeting	Purpose
1	Develop teamwork among members of the steering group Agree on general ‘rules’ on communication and confidentiality in the group Make preliminary decisions about the design of the audit Agree on the standards to be used in the audit on a preliminary basis
2	Review and act on the experience of pilot testing the audit design, standards and data collection methods, including the data collection protocol and tool(s) drafted for the audit Agree on the final arrangements for data collection and analysis and the data protection provisions associated with the audit

Guide for steering group meetings for an interface clinical audit

- 3 Review the preliminary findings for the audit

 Identify any problems in the delivery of care as revealed by the audit findings

 Carry out root cause analysis of the problems or at least the most significant problems

 Identify the actions that are needed to address the root causes of the problems revealed

 Decide when data collection for the audit should be repeated to see if the actions have been effective in improving the quality of patient care

- 4 Review and act on the findings of repeat data collection for the audit

 Decide if further analysis of problems or further actions are needed and carry out such analyses and plans

 Decide if any further work needs to be carried out on the audit and plan the work accordingly

4.3 Inviting people to participate

Whoever has done the initial exploratory work in talking to the clinicians, patients and managers about the interface clinical audit, those who have agreed to participate need to be formally invited by the person or people taking the lead for organising the group. Include the following information in the invitation:

- the purpose and objectives of the steering group
- the plan for meetings, that is, how frequently meetings are likely to take place and the number of meetings
- the time for the meetings. Through contact with all the people on the steering group, select the best time for the majority of members. (If someone is unable to attend, ask him or her to send a representative and have the representative promise to update the steering group member personally on the meeting.)
- the location of the meetings. Select the most convenient location for meetings for the steering group members, if possible, on neutral ground. Requiring some steering group members to routinely travel a long distance to another organisation is not conducive to equality of participation by all organisations. Provide beverages and light refreshments for meetings.
- the participants in the group and their jobs or roles
- the expected contributions of various members of the group. Ensure that all the members of the steering group are aware of their responsibilities in the interface audit and that all the patients to be involved have been trained about their participation by the PPE staff or others.
- for patients, arrangements for compensation for travel expenses, if relevant
- any specific needs of members of the group will be catered for if members let the organisers know about the needs.

4.4 Lead organisation for the audit

The clinical audit staff working in the organisations involved should agree on a lead organisation for the audit based on the interest of clinical staff, meetings with executive directors and the responsibilities of different organisations for the care provided to patients for the subject of the clinical audit. The purpose of the agreement at this stage is to facilitate arranging and acting on meetings of the steering group. Staff working in the lead organisation will:

- arrange and prepare for meetings
- prepare papers needed, the clinical audit detailed proposal, and the data collection tools and protocol
- draft presentations on the findings of data collection and the report on the clinical audit.

An example of an interface clinical audit on care provided to people who deliberately self-harmed

For an interface audit on the care provided to people who deliberately self-harm, these patients are assessed in the emergency department, each patient's GP is informed of the self-harming incident and the patient is cared for in the mental health trust. Therefore, these organisations are represented on the steering group, along with patients who are willing to participate, and clinical audit staff from each of the trusts involved. The lead organisation for the interface audit is agreed to be the mental health trust.

5 How to develop the agreement to be used as the basis for data collection and analysis for the interface audit

5.1 Agreeing on and committing to resources

The clinical audit departments in the organisations involved in the interface audit make the initial decisions about supporting the interface clinical audit. One or more clinical audit departments may decide to develop the data collection forms or data collection protocols or plan the use of existing databases, depending on the audit design and information sharing agreements in place among the organisations involved.

Specific financial commitments, such as paying expenses, should be shared or accepted by the lead organisation. **These arrangements should not be debated in steering group meetings.**

5.2 Data collection considerations

Consider the time span across which patients are selected for inclusion in the audit. One approach that can be used is to stagger data collection across time periods. For example, if the interface audit is on a subject for which care is normally initiated in a hospital, such as stroke, collect data from the hospital for patients cared for in one month. Then, collect data from primary care and social services for patients cared for in the following month. This approach would apply if a clinical audit was being carried out on implementation of an ICP. The approach makes it more likely that the patients will be similar, as they will be using primary and social care services following their inpatient stays, yet patients' anonymity can be maintained in the audit process in each organisation involved.

Discuss the data needed for the interface audit among the clinical audit departments involved. Draft a complete data collection protocol and tool(s) for pilot testing and for subsequent review by the steering group members. Data collection methods may need to be different in each organisation as each organisation may record the required data in different ways.²⁻³ Obviously, the principles of information governance, confidentiality and data protection need to be at the forefront of work carried out on the audit by the clinical audit departments and others involved in the audit.

Data collection methods for an interface audit must be valid and produce reliable data. In developing the data collection protocol and tools for an interface clinical audit, consider all the audit data collection issues in the box.

Data collection issues for an interface clinical audit

There are clear definitions and instructions for data collection for each standard in the clinical audit so that:

- the clinical staff and patients know exactly how decisions are being made about whether or not care meets accepted standards
- data collected can be reliable, that is, the organisations involved can have confidence that the data collected are accurate and complete.

The exact sources for retrieving data needed for the audit are specified in advance and agreed by the steering group.

If data are to be gathered from existing data sources, the existing data sources need to provide valid data.

If data are being collected concurrently with the provision of patient care for a defined time period, there should be assurance that the data can be collected in the agreed time period.

It must be possible to identify unambiguously the patients, events or situations to be included in the audit and how to locate them correctly.

An example of an interface clinical audit on care provided to people who deliberately self-harmed

For the interface audit on the care provided to patients who deliberately self-harm, the hospital is involved in collecting data on the assessment stage of care. Another consideration was how soon following assessment was the patient's GP informed of the self-harming incident. These data are to be collected through the support of the primary care trust.

To contribute to the clinical audit, information on mental health issues, such as dignity and treatment, is to be collected through individual interviews with patients in the mental health trust.

In this example, several methods of data collection are used and each organisation collects data for the aspects of care for which they are responsible. The lead organisation for the audit is to carry out the analysis of all the data collected for the audit.

5.3 Arrangements for ensuring patient and organisational confidentiality and security of the data during collection and analysis

There are essentially three options concerning using patients' personal health information for clinical audit purposes. These are explained in the box.

Options for using patients' personal health information for clinical audit		
Option	Explanation	Conditions
Anonymity in data collection, analysis and presentation	No patient identification data are recorded on any clinical audit data collection forms. Patient identification data are not revealed during analysis or presentation of clinical audit data.	Patients are informed by the organisation that their personal health information may be used for clinical audit purposes, in leaflets, letters or other forms of information provided to all patients. ⁴
Patient consent for inclusion in the clinical audit	It is not feasible or desirable to completely anonymise patient data for some reason. Each individual patient included in the clinical audit is asked to sign a formal consent to the use of personal health information in the clinical audit.	Patients are informed by the organisation about the objectives and design of the clinical audit and how information about them is to be used in the clinical audit.
Patient identification is needed and consent is not practicable	It is not feasible or desirable to completely anonymise patient data for some reason. In addition, it is not feasible to get each patient to consent to the inclusion of personal health information in the clinical audit.	An Information Governance Lead may require a request to go to the National Information Governance Board for approval. ⁵⁻⁶

As all healthcare organisations will have to get approval for sharing information gathered through an interface clinical audit from their Caldicott Guardians and information governance leads, if there is any question about any of the confidentiality and anonymity safeguards not being in place, clinical audit staff should consult with the Caldicott Guardians or information governance leads in the organisations involved in the audit. For a more detailed description of information governance and clinical audit, see *An Information Governance Guide for Clinical Audit* at www.hqip.org.uk.

5.4 Patients as data collectors

Should the steering group for the audit conclude that patients can be involved in collecting data for a clinical audit, the process of enabling patients to be data collectors has to be planned carefully in advance of the time allocated for data collection because meeting requirements can be time consuming. Patients who may be data collectors for a clinical audit should be appointed as volunteers in one of the organisations involved. All volunteers have to have been interviewed for the job consistent with equal opportunities and equality and diversity principles. Applicants as volunteers should have references checked, should have undergone a Criminal Records Bureau (CRB) check and an occupational health check.

As volunteers, patients involved in data collection for a clinical audit should sign the organisation's statement of confidentiality and should complete induction on confidentiality and information governance as well as health and safety, fire, infection control and other related subjects. The requirements for volunteer appointments are in healthcare organisations' volunteer policies.

If patients are to be data collectors for an interface audit, they should also be trained in clinical audit principles and in collecting data for the specific interface audit. The reliability of their data collection should be determined as it would for any staff carrying out data collection for a clinical audit.

5.5 Agreement to ensure patient and organisational confidentiality and security of the data during collection and analysis

Ensure that there is a formal agreement among all the organisations participating in the interface clinical audit. You may need to develop and arrange for the agreement to be completed and signed by an executive director of each participating organisation. The agreement should be executed after the first steering group meeting when the arrangements for data collection for the audit are known. An example of an interface clinical audit agreement is in the box on the next pages.

The purpose of the organisational agreement is to protect the confidentiality of patient and clinician-specific data and to protect the clinical audit departments involved in data collection. The agreement assures that the following provisions are in place to support the interface audit.

- An information sharing protocol for the audit is in place among the organisations involved.
- Confidentiality of patient data and the security of data storage methods are ensured.
- The relevant directors of each organisation have formally agreed to the proposed methods of data collection and sharing.
- Patients have been informed that their personal health information can be used for clinical audit purposes.

The form is intended to be equivalent to the Research Passport that is needed for people carrying out research in NHS organisations.⁷ If staff members from one organisation are collecting data in another organisation, the organisational agreement should also cover the conditions for data collection for the audit among the organisations involved.

ORGANISATIONAL AGREEMENT TO INTERFACE CLINICAL AUDIT

*This agreement applies only to the clinical audit named.
Each organisation participating in the clinical audit has to complete this agreement.*

Title of clinical audit

Organisation

Arrangements for information sharing protocol with other organisations involved

Organisation name	Do you have an information sharing protocol with this organisation?	Action needed
NHS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Voluntary Organisations	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

6 How to pilot test the clinical audit design and arrangements

6.1 Purpose and objectives of the pilot test

After the data collection tools and protocol for an interface audit are developed, the clinical audit departments taking responsibility for the audit need to carry out a pilot test of the audit. The purpose of the pilot is to ensure that the audit can be carried out as designed, accurate data will be retrieved and the audit will facilitate improvements in the quality of care.

The pilot of the interface audit need not include a large number of cases, for example, 10 percent of the intended number of cases or no more than 10 cases. The pilot should use the data collection form(s) intended for the audit and should include writing a report on the pilot of the audit. Specific objectives for a pilot test of an interface clinical audit are in the box.

Objectives for a pilot test of an interface clinical audit

The objectives of the pilot are to ensure the following.

- The patients selected for inclusion in the audit are in the audit, that is, the cases are completely consistent with the cases that the steering group intended to include. If any cases in the pilot do not belong in the audit, refine the method(s) used to find the cases.
- No individual patient can be recognised from the data collected for the audit. If any form of patient identification is being captured in the data, change the data collection protocol and process to ensure complete anonymisation.
- All the data required to measure whether or not standards are being met can be obtained from the named data sources for the audit and are being captured correctly on the data collection form.
- The data collection forms are as clear and easy to use as possible. For example, if data collectors have written notes on the data collection forms used in the pilot when notes were not anticipated, review and revise the data collection form to eliminate the need for data collectors to clarify data being entered on the form.
- Data are not being collected that are not needed for the audit.
- The data can be collected within each organisation in the time allocated for data collection for the audit.
- The degree of inter-rater reliability of data collected among data collectors for the audit is acceptable.
- A short report can be written on the pilot that will show the exact percentage of cases in which care has been consistent with the standards agreed for the audit. If there is any doubt about how the audit findings can be reported, the instructions for data collection and/or the data collection form will need to be amended.
- The time spent on the pilot is consistent with the time estimated to carry out the data collection for the audit. If the time required to complete the pilot shows that it is going to take a lot longer than anticipated to collect data for the audit, the steering group may need to agree to extend the time allocated for data collection or change the design of the audit to require less time.
- The information sharing protocol among the organisations involved in the audit is working effectively.

These objectives apply to interviews with patients or service users and to focus groups. The protocol and findings from these activities need to be part of the pilot test.

Present the findings of the pilot test of the interface audit at the second meeting of the steering group for members of the group to:

- discuss the findings of the pilot test of the audit
- agree that the audit design and standards are fit for purpose, and if not, agree to amendments to the design or standards
- agree that the costs and resources required to carry out the data collection and analysis for the audit are within budget, and if not, agree to amendments needed
- anticipate the potential findings of the audit based on the pilot findings
- discuss and agree on any issues raised by the pilot.

6.2 Data collection and analysis following the pilot test

After any changes in the clinical audit design and arrangements that were indicated by the findings of the pilot test are made, data collection, collation and analysis should proceed.

7 How to facilitate the stakeholders in analysis of problems revealed by the data and in deciding on and implementing actions needed

7.1 Presenting the audit findings

After data collection and collation of the data needed for the interface audit has been completed, the clinical audit staff taking the lead for the audit need to carry out the next steps as previously agreed among the clinical audit staff involved. These steps are summarised in the box.

Steps needed to prepare for the next steering group	
Arrange for clinician review of the preliminary findings	One or more clinicians involved in the audit review the preliminary findings with the clinical audit staff involved. The purposes of this review are to: <ul style="list-style-type: none">• look at the evidence for the patients whose care has not been consistent with the standards used in the audit to ensure that there is no clinical reason at all for the failure of the case to meet the standards• find and correct any errors in data collection that resulted in cases being wrongly classified as not meeting the standards.
Draft a presentation of the findings of data collection	As previously agreed, clinical audit staff draft a presentation on the findings of data collection and circulate the draft to the other clinical audit departments for comments and constructive criticism.
Circulate the presentation to the steering group members	Clinical audit staff send the presentation to the steering group prior to the next meeting and ask group members to read it and attend the group ready to discuss any problems revealed. In a cover communication with the presentation, the chair should restate the need for confidentiality and the basis for the meetings of the steering group, for example, listening to views uninterrupted.

7.2 Discussing problems revealed

At the next steering group meeting, the chair gives the representatives of each organisation the opportunity to speak in turn about the problems or issues that are raised by the interface audit. The standards not met are recorded during the meeting on a flip chart or board so everyone can see the list throughout the meeting.

If the clinical audit has revealed several improvements needed and the steering group members do not feel able to deal with all the issues during the meeting, the chair may create sub-groups to address the improvements.

7.3 Root cause analysis of the problems revealed

The chair or the clinical audit staff members involved lead the steering group members through root cause analysis of the important problems identified by the group using any or all of the following tools:

- fishbone diagram
- asking why five times
- mapping a process of care
- tree diagramming how a desired patient outcome should be achieved
- affinity diagramming all the issues related to a problem to find the key themes the group wishes to pursue.

7.4 Action planning

After the causes of problems have been identified, the group can address the causes. Discussion among group members should be done in a supportive manner, and not become a forum for points to be scored among the organisations.

Following the steering group discussion, the representatives of each organisation need to discuss the meeting minutes and the actions considered as needed by the steering group members. The representatives of each organisation complete a draft action plan, such as the one on the next page. A template for an action plan can be distributed in advance so that each organisation provides the same information for all the aspects needed to take and monitor the actions.

After every organisation has completed a draft action plan, the clinical audit departments together with the chair of the steering group need to look at all the action plans to ensure that all the necessary actions are covered. Some actions may involve more than one organisation, and others may require special attention and facilitation within one or more organisations. The clinicians involved in the steering group may benefit from planning actions together. If clinicians are able to discuss the problems and actions needed informally, outside of a meeting, these issues may be resolved faster than if they are formally discussed in the steering group.

8 How to monitor the implementation of actions and repeat data collection to confirm improvement

8.1 Following up on actions

The final action plan identifies the timing for repeat data collection for the interface audit to show whether or not the actions taken have been effective in resolving the problems identified by the first round of data collection. The chair of the steering group and the clinical audit staff need to monitor the completion of all actions through any of the following approaches:

- asking the leads for each action to provide evidence of the action being done or under way
- observing directly if actions have been done or are under way
- gathering documentation to provide evidence that actions have been taken.

8.2 Arranging for repeat data collection

The steering group needs to decide on when—and how—repeat data collection for the audit will be carried out. The decisions the group has to make include:

- when the data collection is to be repeated, that is, as the changes in practice are being introduced through the actions taken in order to have immediate feedback on their impact, or after all actions have been taken and the actions have been confirmed as completed
- if the number of patients needs to be the same as for the first time
- if all or only some of the standards, for example, those indicating a problem with service delivery, need to be used in the repeat of data collection
- if the process for data collection is to be the same
- if the data collection forms and directions for their use is to be the same. Ideally, the forms should be the same, but the first data collection could have identified problems in data collection that affected reliability of the data and data collection processes may need to be improved.
- if the same data collectors can be used. Ideally, the same data collectors would be used. Whether or not the data collectors are the same, inter-rater reliability of data collection should be determined again.
- if the data are to be analysed the same way
- if the same process for review of the findings, identification of problems and their causes, planning action, and reporting are to be used.

To avoid the possibility that other variables could confound the findings of repeat data collection for the audit, be as consistent as possible with each round of data collection. However, the steering group needs to apply what has been learned at each stage and consider how many cases need to be included in the repeat data collection.

Based on findings from repeat measurement, problems may have to be further analysed and additional actions may need to be taken, with yet another round of repeat measurement to ensure if patient care has improved to the desired and intended standards. When the steering group members consider that the interface audit has achieved its objective(s), the clinical audit staff involved draft the final report of the audit for consideration and agreement by the steering group.

9 How to communicate about the clinical audit and disseminate learning from the experience

9.1 Communicating about the interface audit

After the audit is completed, including the number of repeat measurements needed to assure that the quality of care has improved, arrange to present the audit in each of the organisations involved in the audit. Think carefully about who needs to be aware of the results, and when and how the audit should be presented. Strategies for presentation could include:

- having a clinician who was involved in the audit present the experience to his or her colleagues
- using the regular professional meetings of doctors, nurses, and other healthcare professionals to present the audit with the focus on specific professional issues
- use regular clinical audit or clinical governance meetings in clinical services to present the audit
- if there are inter-organisational meetings for clinical governance or other clinical purposes already in existence, present the audit at these meetings
- help the steering group as a whole to present the audit to all organisations brought together
- at a conference internal to the organisations, persuade a patient to tell the story of the interface audit, how care was before the audit in patients' experience, the experience of participating in the steering group, and the improvements made as a result of the audit, with the patient's own view on these points. A clinical view of the audit can be included to give a balanced picture of the care given and how changes have affected care in each organisation.
- use regular organisational newsletters or intranet communication opportunities in each organisation.

9.2 Disseminating lessons learned about the interface audit experience

In addition, disseminate lessons learned from the interface audit experience and about working in a different way with other organisations. The experience gained can be valuable to present in that it enables closer co-working among the organisations in the future and greater understanding among staff members working in differing organisations, for the same end, to improve the quality of care for patients.

References

1. Adapted from Baker R. What is interface audit? *J R Soc Med* 1994;87(4):228–31.
2. National Institute for Clinical Excellence. *Principles for Best Practice in Clinical Audit*. Abingdon: Radcliffe Medical Press; 2002, p. 33–46.
3. Copeland G. *A Practical Handbook for Clinical Audit*. NHS Clinical Governance Support Team; March 2005, p.12–13. Available at: www.hqip.org.uk/clinical-audit-handbook. Last accessed 6 April 2010.
4. Department of Health. *Confidentiality. NHS Code of Practice*. Leeds: Department of Health; November 2003. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253. Last accessed 6 April 2010.
5. *NHS Information Governance Guidance on Legal and Professional Obligations*. Leeds: Department of Health; September 2007; p. 3. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079616. Last accessed 6 April 2010.
6. ECC Frequently Asked Questions. National Information Governance Board for Health and Social Care. Available at: www.nigb.nhs.uk/eccfrequently. Last accessed 6 April 2010.
7. National Institute for Health Research. *Research in the NHS. HR Good Practice Resource Pack*. January 2009. Available at: www.nihr.ac.uk/systems/Pages/systems_research_passports.aspx. Last accessed 6 April 2010.

Further reading

Crombie IK, Davies HTO, Abraham SCS, Florey C du V. *The Audit Handbook. Improving Health Care through Clinical Audit*. Chichester: John Wiley and Sons; 1993.

Department of Health. *Real Involvement. Working with people to improve services*. London: Department of Health; October 2008. Available from: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089787. Accessed 25 March 2010.

National Information Governance Board. Principles of the National Information Governance Board in decision making and the preparation of advice and guidance, February 2008. Available from: www.nigb.nhs.uk/about/meetings/principles.pdf. Accessed 25 March 2010.

Royal College of Nursing. Measuring for quality in health and social care: An RCN position statement. Publication no: 003 535, undated. Available from: http://www.rcn.org.uk/__data/assets/pdf_file/0004/248872/003535.pdf. Accessed 25 March 2010.