HQIP

Healthcare Quality
Improvement Partnership

Clinical Audit and Commissioning

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Clinical audit tool to promote quality for better health services

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1 Introduction

The Healthcare Quality Improvement Partnership (HQIP) is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. Our purpose is to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales.

Clinical audit may be defined as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery."[1]

In order to facilitate this, HQIP have funded the development of a number of clinical audit support tools to help local teams deliver local clinical audit activity. They are intended to be used as reference material or toolkits to help with the clinical audit process.

This document should be read in conjunction with the following:

- the separate glossary provided
- other relevant tools produced as part of this collection by HQIP.

2 Funding for clinical audit

The Payment by Results tariff includes funding for clinical audit.[2] While no figure is specified, even a figure of (say) 0.25% would result in £250,000 for an acute trust budget of £100 million. Therefore, acute providers are given the necessary finances to conduct audits. Funding for mental health trusts and services in the community is outside of Payment by Results and funding for clinical audit will need to be considered directly by commissioners.

Responsible commissioners should be assured, therefore, that providers actively support clinical audit activity and that it is being done effectively. The expectations of commissioners can be specified in contracts with providers.

3 Need for audit commissioning

World Class Commissioning (WCC)[3] aims to drive up the commissioning capability of local NHS commissioners. It contains a number of organisational competencies that set out the parameters commissioners need to realise this ambition. The Darzi review of the NHS and the report *High Quality Care for All* [4] builds on this and sets new challenges around the quality of care and the publication of quality performance information. WCC is the underlying vehicle for this. Clinical audit is integral to specific WCC competencies and NHS commissioners are now expected to include this in their expectations and contracts with providers.

One of the recommendations from the recent Healthcare Commission report into Mid Staffordshire Hospitals[5], is "PCTs to ensure that they have effective mechanisms to find out about the experience of patients and the quality of care in services they commission". PCTs, therefore, have a duty to monitor the conduct of audit in providers on a regular basis.

As commissioners need to be assured that their patients receive quality care then some mechanism needs to be in place to gain assurance that providers conform to recognised standards of care. They usually specify that providers comply with *Standards for Better Health*[6] which contains a number of specific references to clinical audit, particularly with domain 2 (clinical and cost effectiveness). It is acknowledged that the Care Quality Commission (CQC) will be tightening these requirements for all providers beginning in 2009/2010.

Commissioners need to specify their requirements of providers so that they gain the necessary assurances. This may include allowing commissioners access to facilitate clinical audits while allowing for trusts to support their own staff in all areas, as failure in this regard will also compromise external assessment. Audit commissioning, therefore, needs to be sensitive to a number of regional and national expectations, while allowing for local initiatives at trust and clinician level. A balance needs to be struck to ensure that providers have capacity to support internally-generated audits while gaining assurances that priority topics are audited. Failure to do so could result in providers not complying with *Standards for Better Health*, commissioners not achieving World Class Commissioning competencies, and both groups failing to meet CQC requirements.

Effective commissioning demands excellent communication between all organisations, groups and individuals plus an ongoing commitment to develop the process.

4 Process overview

The process of commissioning for clinical audit follows a cyclical pattern. The commissioner needs to determine the priorities sufficiently in advance of contracts being "signed off" to allow for input from key areas of the PCT, to give provider organisations the opportunity to comment, and to create a final product acceptable to all.

The commissioner needs to be aware of national, regional (SHA and local health economy) and local priorities on an ongoing basis. This can only be achieved by regular liaison with key departments in the PCT, including:

- public health
- other departments with a quality remit
- performance management
- strategic planning
- commissioning.

A draft priority list for the local health community is then shared across the commissioning teams for approval and amendment if necessary. When this has been completed it should then be circulated to all providers for their input. Once the list has been agreed, it is then allocated to the relevant organisation(s) for action.

5 National drivers

5.1 Standards for Better Health (SfBH)

All NHS trusts in England are required to conform to *Standards for Better Health*, whose standards specify areas for clinical audit, including:

- **National Institute for Health and Clinical Excellence (NICE) technology appraisals, clinical guidelines and public health guidance**

  The commissioner needs to include all that are proposed to be introduced by NICE in the year ahead, the time period needing to match the commissioning and delivery cycles. This information is available from the NICE website and use of the Forward Planner (available from the NICE website) is recommended to identify topics.

- **National Service Frameworks (NSFs)**

  Most NSFs contain reference to the need to conduct annual clinical audit of specific aspects of care. The actual audits are usually only referred to as “there should be an annual audit” without further qualification. This does allow some latitude to commissioners and providers to develop suitable audit tools under the above umbrella which are likely to be run on an ongoing basis and can be used to identify year-on-year changes.

- **National Confidential Enquiries**

  There are currently national confidential enquiries (NCEPOD – Patient Outcome and Death, CEMACH – Maternal and Child Death, NCISH – Suicide and Homicide). Each of these gathers data on an ongoing basis from trusts and produces reports of findings. The frequency of reporting is not regular. The reports may include a recommendation that trusts audit a particular aspect of care or service provision in an identified area but often reference to these is embedded in the reports and needs to be teased out.

- **National clinical audits**

  External assessment requires that trusts participate in national clinical audits. Many national clinical audits are contract managed by Healthcare Quality Improvement Partnership (HQIP) and include the National Clinical Audit and Patient Outcomes Programme (NCAPOP) funded by DoH. There are a number of national audits that are outside of the NCAPOP programme (e.g. TARN for Trauma, ICNARC for Intensive Care) that should also be considered for inclusion in the priority list. Each audit has its own methodology which can impact on how it is conducted at trust level.

  Both commissioners and providers need to be aware that the actual number of “national audits” is currently unknown with several projects styling themselves as such with no actual evidence that they are either “national” or “audits”. Each organisation should have a systematic process to determine participation in each audit based on local priorities. It is expected that some central organisation will develop a process for ratification that all bodies, including assessors, will use.

- **NHS Litigation Authority standards**

  The NHS Litigation Authority (NHSLA) manages the risk management standards.[7] This includes a number of areas for audit dependent on what level of compliance the trust has with standards. As provider trusts aim for higher compliance then additional audits are needed. The commissioner needs to consider if it is appropriate to include these extra audits within the commissioned priority list or whether they constitute local, provider-owned, work.

- **Other areas**
  - suicide across all sectors
  - Infection control, for all trusts using the Infection Prevention Society audit tools
  - Those identified by the National Patient Safety Agency. These are recommended as necessary by the NPSA depending on reports produced.

Some of the above refer to audits that are ongoing year-on-year e.g. infection control, suicide, NSFs, while some others (e.g. NICE guidance) will be entirely different each year. Confidential enquiries may make recommendations that require clinical audits.

5.2 Other national drivers

The following also should be considered as potential national drivers for clinical audit, although they do not have the same corporate imperative as SfBH.

- **Essence of Care**[8]

  The many strands of good practice within this document should be considered as potential topics for audit.

- **Mental Capacity Act**[9]

  This applies to all organisations and should be considered, either separately or as part of other commissioned audits.

- **Safeguarding (Adults and Children)**[10–11]

  This applies to all organisations and should be considered, either separately or as part of other commissioned audits.

- **Accreditation**

  Many provider departments are required to conduct audits to demonstrate their fitness for purpose and for accreditation by relevant bodies. While this driver may be thought of as an issue for provider organisations, commissioners may specify relevant clinical audits within their programme of work.

The commissioner should identify, from the above list, the audits that are relevant to the local health community.

6 Regional and local drivers

6.1 Strategic Health Authorities (SHAs)

SHAs also create topics for audit. These can be either via directives to trusts or as a requirement to support other initiatives. Commissioning for Quality and Innovation initiatives (CQUINs)[12] may require audits to be done so that trusts can demonstrate that they meet the standards etc. needed. SHAs may also require audits to be conducted across their area in all relevant organisations on specified topics. The actual input, choice of topics and processes will vary by SHA.

6.2 Local initiatives

There are a number of PCT initiatives that could require clinical audits, including (for all commissioners):

- Director of Public Health Annual Report
- Commissioning intentions
- World Class Commissioning implementation
- Audits resulting from Patient Reported Outcome Measures (PROMS)[13] plus issues that are specific to a particular health community.

Provider organisations themselves may request that certain audits are included in the list as doing so will increase the priority given by clinical and other staff.

7 Confirmation

The identification of all potential audits for the local health community should always demand engagement with many different groups in the commissioning function of a PCT. Once the full list created above is available then it must be shared with all partners in the PCT including, at least:

- public health
- contract managers
- commissioning leads
- quality and governance leads
- patients and carers.

Experience has shown that this process is essential to develop a list that accurately reflects both national and local priorities. It is normal for changes to be made to the programme as a result.

8 Agreement with providers

The priority list must be shared with all providers in the local health community, through their clinical audit leads. This is to ensure that it is achievable and that all parties can work toward the common goal. At this time, it is possible that two or more audits can be combined into a single project.

When there is general agreement of the content, then the workload for each organisation can be finalised and documented.

Some audits, particularly for NICE guidance, need to be conducted across organisations. These should be noted and appropriate leadership for the project confirmed. As such projects may be run across trusts then appropriate provision should be made regarding Data Protection Act and Information Governance requirements.[14–15]

Providers may also indicate that certain items of NICE guidance are not applicable to them e.g. as they do not provide the service, in which case they should be removed from the programme.

Commissioned audits should be included in provider audit programmes and treated as a priority. It is acceptable for providers to add their own requirements to the commissioned list, but the original audit should not be “lost” in doing so. The commissioner will still require a report (see section 14) to include specific from the original agreement.

9 Corporate approval

When the above processes have been completed, then the priority list can be submitted for corporate approval. For PCTs, this could be via the Professional Executive Committee or similar group with responsibility for clinical leadership, and for provider organisations through the committee with designated responsibility for clinical audit. The priority programme may also be added to trust websites.

Corporate approval should be supported by providers ensuring that the programme is treated as a priority within the provider organisation. This could be included in the provider’s clinical audit policy.

10 Inclusion in contracts

The priority audits should be specifically included in contracts once they have been approved. Clause 16 of the standard contract[16] contains specific reference to clinical audit and may be the most appropriate place to include the audit programme requirements. The commissioner may decide to refer back to the priority list with a summary statement in the contract, or may actually list all the relevant audits (but see Section 11).

To prevent potential confusion, the contracts need to state explicitly that providers will supply information regarding the progress of the audits in the programme and that they will release the findings of the audits.

11 In-year changes

Changes to the commissioner's priority programme are inevitable. These can arise for a variety of reasons, the most common being:

- Additional NICE guidance not originally in NICE's forward programme (particularly Single Technology Appraisals)
- Delays in NICE guidance from advertised issue date
- Delays in national audits
- Delays in conducting audits in provider organisations (for valid, acceptable reasons), but see section 13 below
- Additional audits urgently required from reports from national bodies e.g. Care Quality Commission, National Patient Safety Agency.

These changes are usually unpredictable and unavoidable and need to be factored into the priority programme, following consultation with all parties. If the audits have been listed in the contract, then some mechanism must be identified to update this.

12 Monitoring

Providers need to provide assurance that audits are progressing satisfactorily and that action plans are developed and implemented. It is recognised that some providers will comply with the standards of some national audits, in which case evidence of compliance should be available.

A systematic approach should be agreed between commissioners and providers that allows for monitoring to be done in a simple, straightforward way.

13 Non-completion of audits

Once the programme has been agreed then the providers have an obligation to conduct the audits robustly. However, there may be occasions where progress is delayed. Two particular issues are:

- **Audit not being conducted**

  This should not occur in theory as providers have a contractual obligation to do so. However, it is recognised that this must be considered a possibility e.g. due to an unforeseen lack of capacity. If the audit is not being conducted as agreed then the commissioner must be made aware as soon as possible and discussions held to determine remedial action. Recourse to contract managers should only be made when all opportunities to resolve the issue have been exhausted.

- **Lack of collaboration between organisations**

  Those audit topics that have been identified by the commissioner as relevant to more than one provider may be delayed due to lack of effective working between organisations. The commissioner should be able to identify when this occurs through the regular monitoring, and working with all parties, achieve resolution of issues.

  Where audits are not completed in-year (for valid, acceptable reasons), then they need to be carried over into the following year.

14 Reporting

Contracts usually require a six-month or annual report from providers of audits done, actions taken and improvements made. Unless the format of the report is determined by the commissioner, then the standard reporting format of the provider should be used.

Commissioners need assurance that the audit has identified either compliance with standards or an action plan to meet standards. Evidence of these should be included against each audit in the commissioned list as a regular part of the report.

15 References

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Appendix. Indicative programme creation process (this may vary depending on local arrangements)