



HQIP

Healthcare Quality
Improvement Partnership

How to Implement Local Changes from National Clinical Audit — A Guide for Audit Professionals in Healthcare Organisations

Jean Schofield and Janet Jenkins
Clinical Audit Development Managers
Sheffield Teaching Hospitals NHS Foundation Trust

Clinical audit tool to promote quality for better health services



**Revised -
minor changes to wording
January 2012**

Previous versions:

September 2009 (first publication)

Contents

Contributors	iii
1 Overview	1
1.1 Introduction	1
1.2 Aim of guide	1
1.3 Background	1
1.4 Definition of national audit	2
1.5 National Clinical Audit and Patient Outcomes Programme	2
1.6 Participation in national clinical audit	3
1.7 Using this guide	3
2 How national clinical audit can lead to change in practice	4
2.1 Key messages	4
3 Applying principles of change	5
3.1 Six Steps for Implementing Change	6
4 How to plan for effective implementation of local change	8
4.1 Resources	8
4.2 Data collection	10
5 How to use national clinical audit locally to drive quality improvement	11
5.1 Enabling structures	11
5.2 Effective dissemination of national results using a local report	11
5.3 Development of local recommendations and action plan	12
5.4 Using existing communication structures	13
5.5 Local early data analysis	13
5.6 Monitoring compliance with standards	14
5.7 Using available resources	14
5.8 Monitoring change	14
5.9 Requirement for re-audit and additional audit	15
5.10 Business planning	15
5.11 Service development and redesign	15
5.12 Inform commissioning process	16
5.13 Quality assurance	17
6 Useful information	17
6.1 Example of good practice	17
References	19
Further reading	19
Appendices	
1. Change management information	20
2. Planning for data collection and entry	26
3. Stage 4 – Making improvements	30

Contributors

We wish to acknowledge and thank the following for their contribution to the development and content of this guide.

Attendees at HQIP 'Working Together to Reinvigorate Clinical Audit' Conference, April 2009

Clinical Effectiveness and Evaluation Unit, Royal College of Physicians, Rhona Buckingham, Manager

HQIP, Darren Thorne, National Lead for Local Quality Improvement

HQIP Clinical Audit Product Suppliers, 2009

Institute of Healthcare Management, Sue Hodgetts, Chief Executive

Mid Yorkshire NHS Trust, Professor T J Hendra, Medical Director

National Audit & Governance Group members

National Clinical Audit Support Programme, Graeme Aldington, Business and Project Support Officer, Kimberley Greenaway, Project Manager (Cancer Audits)

NHS Institute for Innovation and Improvement, Julia Taylor, Programme Director, Service Transformation

NHS Sheffield, William Gray, Strategy Manager Specialised Services

Sheffield Clinical Audit/Effectiveness Managers Reference Group

Sheffield Teaching Hospitals NHS Foundation Trust, Clinical Effectiveness Unit, Vicky Patel, Education Advisor

Sheffield Teaching Hospitals NHS Foundation Trust, Clinical Informatics, Stephen Stewart, Assistant Clinical Informatics Manager, Daniel Roberts, Clinical Informatics Lead

Sheffield Teaching Hospitals NHS Foundation Trust, Local Clinical Leads for National Audit, Professor C R Chapple, Dr P Lawson, Dr J Hill

Sheffield Teaching Hospitals NHS Foundation Trust, Dr AJ Anderson, Consultant Physician and Geriatrician Emeritus

South West Audit Network members

University Hospital, Walsgrave, Coventry, Linda Belgrove, Clinical Audit and Effectiveness Lead Coordinator and Trust NCEPOD Reporter

University of Sheffield Health Sciences Library, Joanne Marsden, Outreach Librarian

Yorkshire and Humber Clinical Audit and Effectiveness Group Managers

1 Overview

1.1 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.”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.

1.2 Aim of guide

This guide aims to help audit professionals in healthcare organisations:

- create the right environment for change
- provide strategies for successful implementation of local changes from national clinical audit
- encourage organisations to identify areas of clinical risk or areas for improvement at an early stage
- support their organisation to comply with performance indicators related to audit and participate in the National Clinical Audit and Patient Outcomes Programme.

1.3 Background

National clinical audit is designed to improve patient outcomes across a wide range of medical, surgical and mental health conditions. Its purpose is to engage all healthcare professionals across England and Wales in systematic evaluation of their clinical practice against standards and to support and encourage improvement in the quality of treatment and care.²

Historically national audit projects were run and coordinated by the Medical Royal Colleges and professional bodies. The National Institute for Clinical Excellence (NICE) inherited a programme of Department of Health (DH) commissioned national audit projects, with ten national sentinel audits towards the end of 1997. The number of national audits continued to grow with the National Clinical Audit Support Programme (NCASP), Information Centre for Health and Social Care managing audits in cancer, coronary heart disease and diabetes. A

National Clinical Audit and Patient Outcomes Programme (NCAPOP) was introduced for 2005/06 managed by the Healthcare Commission.

In 2006 the Chief Medical Officer's report *Good Doctors, Safer Patients* called for the reinvigoration of clinical audit to enable it to reach its potential as a rich source of information to support service improvement, better information for patients and other activities such as revalidation of clinicians.

The Healthcare Quality Improvement Partnership (HQIP) was awarded the contract to run the NCAPOP from 1 April 2008. The National Clinical Audit Advisory Group (NCAAG) act as the steering group to the NCAPOP, providing advice and guidance on the overall programme of work, and in particular to consider proposals for new audits or for discontinuing audits.

1.4 Definition of national audit

A national clinical audit has been defined by HQIP as either a project funded by the NCAPOP or, although separately funded, meets all of the following criteria:

- national (England) coverage (achieved or intended)
- main focus is the quality of clinical practice
- measures practice against clinical criteria/guidelines and/or collects outcomes data
- applies the audit cycle and/or monitors clinical/patient outcomes data in an ongoing way
- is prospective i.e. does not include retrospective reviews of adverse outcomes such as confidential enquiries
- includes patients in their governance and takes data from patients themselves.

Most national clinical audits have been developed because they are in an area of healthcare that is highly important and where it is felt that national results are essential to improve practice and standards. In all cases they form part of a broader approach to improve quality, and fit into the information strategy of the condition involved, especially in areas like cancer or diabetes which have national information strategies. Such audits are backed by the relevant Royal College and the national director concerned. They also usually have the support and engagement of the relevant national voluntary organisation which represents patient interests.

1.5 National Clinical Audit and Patient Outcomes Programme

The NCAPOP is a set of centrally funded national projects that provide local trusts with a common format by which to collect audit data. The projects analyse the data centrally and feedback comparative findings to help participants identify necessary improvements for patients. Most of these projects involve services in England and Wales; some also include services from Scotland and Northern Ireland. The programme comprises more than 20 clinical audits and will be extended to other areas of healthcare that are considered a priority by NCAAG and the DH. A current programme can be accessed via www.hqip.org.uk. These national audits often consist of three parts: organisational audit, clinical audit and patient survey to enable measurement of the structure, process and outcome of care thereby providing a holistic view of care.

Organisational audit provides information on the current organisation and structure of care at a particular point in time for the specific patient group being audited e.g. lung cancer, inflammatory bowel disease (IBD). It will typically cover facilities, numbers and grades of staff involved in care, skill mix of multidisciplinary teams, access to diagnostic and therapeutic

facilities, referral systems, access to services/clinics, service users/carers involvement, etc. Clinical audit obtains clinical data to provide information on the process and delivery of care by measuring against evidence based standards. Patient surveys provide information on patient/service users' experiences and perceptions of the standards of care received from healthcare professionals. This is an important aspect as patients' understanding of care received and their priorities may differ from those of the service provider.

Clinicians and their employing trusts should view a well designed and effective national programme as an essential tool for them to improve services and assess performance.

Additionally HQIP are developing and promoting links with audits outside the NCAPOP

"It is important to include patients' views on the quality of the service they received."

Medical Director, The Mid Yorkshire NHS Trust

framework (listed on HQIP website under Other national clinical audits & registries).

1.6 Participation in national clinical audit

Trust participation is not mandatory for all national clinical audits. However, there is an expectation that eligible trusts will undertake all relevant projects. Organisations should therefore make an informed decision on which audits they will undertake based on the requirements of:

- the Care Quality Commission (CQC) e.g. performance indicators, Engagement in Clinical Audits indicators and their assessment processes
- other regulatory bodies
- local objectives/priorities.

Where an organisation decides not to participate in a national audit, a clear rationale for non-participation should be available as evidence to justify this decision.

1.7 Using this guide

The guide does not provide full details of how to undertake an audit which is already described in *New Principles for Best Practice in Clinical Audit*¹ but seeks to highlight the essential steps to facilitating change as a result of national and local findings. It is divided into six sections:

- Section 1 gives the background to national audit, describes what it is and provides information on the national programme for those that would like a refresher or may be new to national audit work.
- Section 2 makes key suggestions for overcoming potential limitations to success in implementing change from national clinical audit findings.
- Section 3 explains briefly the principles of change and signposts you to information on relevant literature in Appendix 1.
- Section 4 offers practical suggestions for local planning and participation in national audit.
- Section 5 shows you how you can use national clinical audit locally to drive quality improvement.
- Section 6 includes good practice examples.

Local clinical leads for national audit were asked to provide reflections on their practical experiences to inform the content of the guide. Some of their comments have been included in this guide.

2 How national clinical audit can lead to change in practice

Clinical audit and patient outcomes monitoring are two closely related activities which aim to ensure that all patients receive the most effective, up to date and appropriate treatment delivered by clinicians with the right skills and experiences.²

National clinical audit should lead to better patient outcomes by improving professional practice and the general quality of services delivered.

These projects allow:

- individual healthcare professionals and teams to measure their care against national standards/guidance
- production of national comparative data for individual healthcare professionals and teams to benchmark their practice and performance
- local bodies to identify and make local improvements for patients
- patients to question the quality of their care and exercise choice
- the Care Quality Commission to corroborate local bodies' self assessment against national standards
- the DH and NHS Wales to assess progress against national initiatives.

2.1 Key messages

Undertaking national audit poses specific challenges for organisations, healthcare professionals

“The benefit of involvement in national audit projects is that it allows us to have a view on what is happening nationally within the country, both in terms of directing care and introducing the latest new developments into our trust.”

Trust Clinical Lead, National Audit of Continence Care

and clinical audit staff. Some useful tips to overcome these are listed below.

- Engage senior clinicians, managers and frontline clinical staff at the start to promote commitment to national audit and ownership of national audit projects.
- Ensure national audit is prioritised and valued as part of healthcare governance, the quality improvement agenda and at board/strategic level in your organisation.
- Review and develop strategies to manage any potential organisational problems and barriers to change, such as poor relationships between clinicians and managers, within multi-professional teams and across specialties.
- Explore ways to obtain funding for adequate resources to support projects specifically those which require continuous data collection.
- Where possible set up systems for continuous data collection processes which become an integral part of routine practice.

- In setting up systems address capacity issues and allow for the possibility of data set expansion.
- Develop support systems for specialities/services/areas where participation in more than one audit on the national programme is required.
- Ensure good communication with and involvement of appropriate key stakeholders for complex audit that is multi-professional and/or bridges more than one healthcare setting e.g. secondary, primary, mental health and social care.
- Provide access to training for both clinical and audit staff to develop the necessary skills to make best use of national audit to improve patient care. Examples of relevant training are clinical audit, IT skills, data analysis, facilitation, leadership, project management, change management including organisational and personal change, team work, communication, quality improvement.
- Apply appropriate change management strategies to combat change fatigue/poor experiences of change in NHS staff.

3 Applying principles of change

What do you think best facilitates change in practice from national audit findings?

“Buy-in by senior management in the organisation that this particular national audit is of importance to their external reputation. There are many ‘national audits’ run by specialist societies, special interest groups, as well as colleges and the NPSA, and it is difficult to have the data requested readily available unless the organisation is prepared to invest in infrastructure or has existing electronic data collection systems that make responding with accurate results easy.”

Former Trust Clinical Lead, National Sentinel Audit of Stroke

There is a wealth of information on change management and quality improvement with numerous tools, models and approaches described in the literature. For change to be successful in relation to national audit projects it should be recognised that “No single method, strategy or tool will fit all problems or situations that arise. Managers in the NHS need to be adept at diagnosing organisational situations and skilled at choosing those tools that are best suited to the particular circumstances that confront them.”³

Advice on change management specifically in relation to clinical audit can be found in *Principles for Best Practice in Clinical Audit*¹ Stage 3: Implementing change, pages 81-92; Stage 4: Sustaining improvement, pages 93 to 106; and *Implementing Change with Clinical Audit*.⁴

Due to the plethora of existing literature this guide does not provide detailed information on change management. However, to enable you to access relevant tools and products some helpful resources have been compiled in Appendix 1.

Change shouldn't happen in a random, uncontrolled way. A structured approach to implementing change is most likely to be effective and result in successful outcomes. Having a change management strategy built in at the start of a project is advised rather than trying to add one when change is proving problematic or not taking place. Try to create some joint ownership of the audit with clinicians, managers and audit specialist staff. Identify local barriers to change using change knowledge. These will be different depending on the type of audit undertaken. Organisations have different and changing needs and local needs are best met by local solutions. Effective and regular communication at all stages of the change process is essential both at strategic and operational levels.

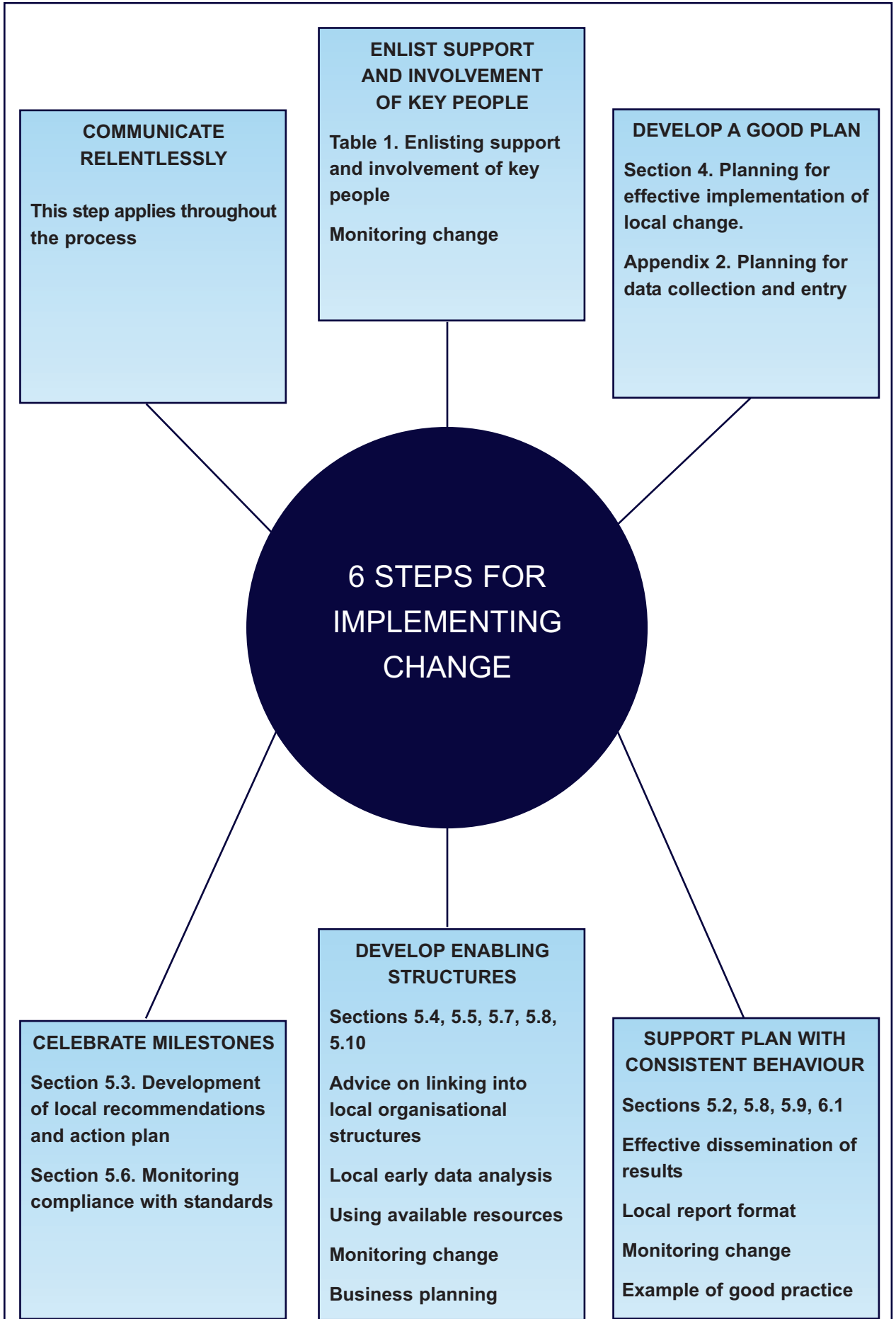
3.1 Six Steps for Implementing Change

The Six Steps for Implementing Change is one useful example of an approach that you could apply adapted from the *Change Management Toolkit — Navigating Change in the NHS*.⁵

- **Step 1 — Enlist the support and involvement of key people.**
To ensure the momentum and buy-in to a change process, identify key stakeholders and ensure that they are involved and their contribution is valued. Use the stakeholder team as agents of change across the wider organisation(s) and try to achieve a good mix of skills, authority, resources and leadership.
- **Step 2 — Develop a clear project plan.**
Create a simple plan for life span of the project, which clearly defines roles and responsibilities. Get people involved in the plan, especially if they are directly affected by it. Make sure that the plan is built in small, achievable chunks with realistic timescales.
- **Step 3 — Support the plan with consistent behaviours.**
Whatever the characteristics of the change are, cost-cutting, behavioural, or ways of working, it is important to be seen to be “walking the talk”. People are only likely to adopt change if it is demonstrated by all levels (and particularly senior levels) of the organisation.
- **Step 4 — Develop “enabling structures”.**
Recognise what needs to happen to support the change. Training workshops, communication sessions, team meetings that are aligned to the change will help people understand the reasons for the change, and buy-in to the process.
- **Step 5 — Celebrate milestones.**
When milestones are achieved, celebrate the fact that progress has been made. Recognising progress will maintain motivation and stakeholder interest, and give confidence that the longer term vision is achievable.
- **Step 6 — Communicate relentlessly.**
This is probably the most important activity of all. Communicating effectively can motivate, overcome resistance, lay out the pros and cons of change, and give employees a stake in the process.

These steps are illustrated in the diagram on the next page in relation to the relevant sections in the guide and cross referenced within the text in sections 4 and 5.

Applying the steps for implementing local change from national clinical audit



4 How to plan for effective implementation of local change

“Fail to plan, plan to fail” (famous old military saying)⁶

Good preparation and planning at the start are essential for an audit project to be successful in implementing change (Step 2. Develop a clear project plan). The main principles and guidance for undertaking clinical audit are the same for both local and national audit. However, the different challenges that national audit brings mean that specific attention should be paid to certain parts of the audit process. These are described with the rationale in Table 1 and Appendix 2.

Audit professionals should ensure national clinical audit is an integral part of their organisation’s clinical governance, clinical effectiveness, quality improvement and informatics strategies and is included as a priority on their clinical audit programme. “Mechanisms to maximise organisational support and commitment should be invoked at the recruitment stage. Projects should be embedded into clinical governance strategies.”¹

The major findings from a national project *Action on Clinical Audit*⁷ state that “an audit project is most likely to have a significant and beneficial impact upon standards of care when it proceeds from (and in turn informs) the clinical and corporate priorities of a Trust and can secure explicit support at Board level.”

Creating the right environment for change should include promoting a culture in which participation in national audit is supported and actively encouraged, ensuring good leadership and fostering a positive attitude in senior management, providing skilled facilitation of projects and sufficient and protected staff time.

4.1 Resources

National audit projects are resource intensive at both national and local level. They require a significant commitment from organisations. It is therefore important to identify the resources required to undertake the audit at the planning stage e.g. IT/informatics staff to build new systems to enable data collection to be part of routine electronic data collection, time commitment for clinical staff to data collect, additional staffing for data entry, validation.

Table 1. Enlisting support and involvement of key people (Step 1)

Audit process	Rationale
<p>Include national audits in your trust clinical audit programme</p> <p><i>See Clinical Audit and Commissioning available from HQIP</i></p> <p><i>See Clinical Audit Programme Guidance Tools available from HQIP</i></p>	<p>This will ensure:</p> <ul style="list-style-type: none"> • national audit projects are given a high priority in the trust and in directorates/divisions/specialties/services, etc. • implementation is monitored quarterly/annually as agreed within your organisational structures • evidence is available for the Engagement in Clinical Audit indicators.
<p>Identify a clinical lead/champion</p> <p><i>“A review by Ham et al. (2007) showed a significant deficit in project management skills across the NHS, specifically in the management workforce. The report found that this was hindering effective progress in delivering sustainable service improvement.”⁹</i></p>	<p>This person is essential as the success of any project is usually due to having a project manager who has:</p> <ul style="list-style-type: none"> • project management skills • a proactive project management style • leadership skills • a commitment to leading the team through the whole audit process from the start through to implementing and sustaining change in practice <p><i>“Good clinical audit requires teamwork. Effective teamwork requires effective leadership.”⁵</i></p> <p>Leaders can influence a team to achieve the recommended changes. More than one lead may be needed if the audit covers more than one organisation.</p> <p>A clinical champion is a senior healthcare professional and who is:</p> <ul style="list-style-type: none"> • seen as an expert in their field • respected by their colleagues/MDT • has the authority to influence/implement change.
<p>Engaging clinical and managerial staff</p>	<p>It is essential to obtain “buy in” from key staff who can:</p> <ul style="list-style-type: none"> • influence change in the clinical areas e.g. consultants, nurse directors, senior therapists, GPs, district nurses • use findings to facilitate service development and/or redesign e.g. service managers, business managers

Audit process	Rationale
	<ul style="list-style-type: none"> change practice at patient/staff interface e.g. healthcare professionals. <p>If the audit covers care across more than one healthcare setting allow adequate time for the project lead to engage relevant staff across the organisation/partner organisations e.g. primary care, secondary care, mental health, social care.</p>
<p>Formation of stakeholder/steering group with a clear remit</p>	<p>Setting up a stakeholder group of all appropriate staff is vital as part of the engagement process and to manage the project.</p> <p>The group should have clear terms of reference which define their role in:</p> <ul style="list-style-type: none"> the management of the project working as a team producing deliverable outcomes.

4.2 Data collection

Data collection may be continuous (prospective) e.g. cardiac and cancer audits or “snapshot” i.e. a specified time period. Snapshot may be either retrospective e.g. in stroke audit, or concurrent e.g. in continence audit.

The issues to be considered when planning data collection and entry differ according to the type of data collection for the project.

“The key to successful continuous data collection is having clinicians and managers who are engaged and motivated, crucially the lead clinicians and senior management. They should understand what needs to be collected, want to collect the data, be keen to see data returns and want to improve their service and their practice compared to national results and based on intelligence from the audit process.”

Stephen Stewart, Assistant Clinical Informatics Manager

Data collection has been described in some detail in Appendix 2, as it is essential for national clinical audit data to be reliable and complete. It is in the public domain, is used for national comparators and to inform change.

“Only if data quality is consistently good can national audit accurately identify areas of good or poor practice.”

Trust Clinical Lead for National Lung Cancer Audit

5 How to use national clinical audit locally to drive quality improvement

“We can only be sure to improve what we can actually measure”.⁸

“There is a need to put more emphasis on measuring and comparing performance, and developing leadership skills and capabilities in the use of performance data, linked to incentives that can drive quality improvements”.⁹

Clinical audit is a quality improvement tool. The results of national audit can be used in a variety of ways to drive and support improvements in patient care and service provision. The following information in this section provides guidance for how this might be achieved.

5.1 Enabling structures

“Recent experience by the NHS Institute for Innovation and Improvement which suggests that the biggest area of unmet need amongst local NHS organisations is in ‘hands-on’ improvement skills both for leaders and front-line teams, and how to align change capability with local strategic imperatives”.⁹

In order to use national clinical audit findings locally to drive quality improvement, leaders and front-line teams need to have an understanding of and the skills related to change management. Training workshops, change information etc should be available to support any development needs e.g. Royal Colleges national audit regional workshops may include sessions on change management skills (Step 4: Develop enabling structures).

5.2 Effective dissemination of national results using a local report

“Proper dissemination of the results locally and follow up discussions with those who can influence service development.”

Trust Clinical Lead, National Falls & Bone Health Audit

A national audit report provides detailed information on the results, which should act as a driver for improvement. It is important to interpret the local findings in relation to the local setting and develop local reports. They should incorporate both key national and local priorities and recommendations for change. The reports from the National Sentinel Audit of Stroke and National Falls and Bone Health Audit now include key indicators on the quality of care for those services and summarise the key recommendations into a “top ten.”

To use the results effectively they should be disseminated to all appropriate levels in the Trust e.g. chief executive, medical director, chief nurse, board, stakeholder group, operational groups, clinical staff.

Stakeholder groups may choose for the clinical lead and the audit lead to provide a first draft report for discussion at the stakeholder meeting to ensure all are able to discuss the findings and contribute to the process of producing a local report.

The format of local reports should be tailored to the audience both in length and content. Consider what you want a particular audience to do with the findings. Make sure the report highlights those specific issues that require their action. For example, the board and healthcare governance group would require a brief summary of key findings and any clinical risk issues.

For those national audits which have three parts, organisational audit, clinical audit, and patient surveys, it is important to ensure a report with an action plan is produced for each part. Although these audits may be conducted several months apart it is essential that the findings are addressed specifically for each one but also considered in collaboration as a whole. Once all results are available a combined local report may be produced to support change. Triangulation of results will better inform any practice or service change.

It is essential to disseminate results but it is important to note that the stakeholder group “should avoid relying on feedback alone as the method of implementing change; although feedback of data alone can occasionally be effective, change is much more likely if it forms part of a more complex set of change processes/interventions.”¹ This is one point in a useful list of key points for making improvements detailed in the Stage 4 section of this book (list reproduced as Appendix 3). A meta analysis also concluded that “audit and feedback effectiveness is improved when feedback is delivered with specific suggestions for improvement, in writing, and frequently.”¹⁰ See *Template for Clinical Audit Report* available from HQIP.

5.3 Development of local recommendations and action plan

Any local report should include recommendations and an action plan. Dissemination of results will not in itself ensure change. It is much more likely if a specific action plan is developed with clear accountability for implementing the recommendations e.g., named consultant, ward manager, senior therapist. This should also include a timescale for completion of actions to provide a target and motivate staff. The use of a timescale is illustrated in this example of actions required from the National Sentinel Audit for Stroke results. Some actions can be taken quickly e.g. if poor compliance with “patient weighed at least once during admission”, action would be to raise awareness with staff and ensure weighing equipment available in one month. Quick wins such as these should be celebrated (Step 5: Celebrate milestones). Recognising progress will help keep the interest of stakeholders to continue to work towards other actions that may take longer e.g. if not achieving “direct access from A&E to a stroke unit” this may necessitate development of a business plan to redesign and reconfigure services in one year.

National audit suppliers may also provide a local action plan. For example the National Cancer Audits Local Action Plan (LAP) Tool Kit is provided by NCASP to facilitate service improvement. It is sent to trusts as part of the dissemination process for cancer sites national annual audit reports e.g. lung or oesophago-gastric. It provides trusts the key recommendations that are of national concern already entered into the LAP with suggested actions. Trusts can then consider their own local performance and identify which of these are pertinent to their own practice. An example of a LAP can be accessed at [www.ic.nhs.uk/webfiles/Services/NCASP/Cancer/New%20web%20documents%20\(Lung\)/LUCADA%20-LAP%20template%20for%20website.doc](http://www.ic.nhs.uk/webfiles/Services/NCASP/Cancer/New%20web%20documents%20(Lung)/LUCADA%20-LAP%20template%20for%20website.doc).

It is important to include the clinical and managerial staff in the development of local recommendations and action plan to gain ownership and “buy-in” for any required change in practice. Again stakeholder groups may choose for the clinical lead and the audit lead to provide a first draft action plan for discussion at the stakeholder meeting to ensure all are able to contribute to the process and agree on actions to be taken.

Once the action plan is complete stakeholder group members, both strategic and operational, should demonstrate their commitment to change so that those staff who need to implement changes will be more likely to adopt change (Step 3: Support the plan with consistent behaviours).

5.4 Using existing communication structures

An important method for influencing change is to incorporate the dissemination of results and monitoring of action plan progress into existing local organisational and management structures e.g. directorate/division meetings, nursing forum/nurse director meetings, service boards, drugs and therapeutics committees, clinical governance meetings, NSF/national strategy implementation groups, relevant care pathway work. For those audits which include more than one organisation consider existing interface meetings or regional networks. This keeps national audit on the agenda and can also ensure continued monitoring so that any improvements made are sustained. An example of this would be the NHS provider trusts and cancer networks including discussion of results, variations of practice across the network in their regular MDTs and specific site group meetings.

Organisations should include information on national audit work in their annual clinical audit report as another way of disseminating results, changes in practice and service improvement to clinical staff, managers, trust board and commissioners. See *Template for Annual Clinical Audit Report* available from HQIP.

Remember that it is important to maintain good communication both verbal and written with all relevant staff through the change phase. Use all the communication methods you would normally use for a local audit (Step 6: Communicate relentlessly).

5.5 Local early data analysis

Timely reporting of results is crucial. Time between data collection and receipt of national results can be anywhere from 3 to 15 months and the longer this takes the less relevant the data are to current practice. It may also reduce the impact of and interest in the results and report. There may also be a clinical governance issue in that areas of clinical risk may have been identified which need urgent action rather than waiting until the full results are available.

One way to address this is to undertake local data analysis at the end of data collection with instant feedback of results to initiate change.

A note of caution would be that algorithms for calculating domain and total scores and case-mix adjusted outcomes may not be known locally and this can therefore have an impact on the accuracy of some locally analysed results.

5.6 Monitoring compliance with standards

Where a national audit has been running for a number of years it can be useful to review achievement of key standards of care over time. This will help motivate clinical staff where care is shown to have steadily improved. It can alert them to areas where little progress has been made or care appears to have deteriorated which will then require further work to resolve. It will also be of interest to business and general managers for any work they may be doing to review services and planning for service development.

5.7 Using available resources

The suppliers of national audit produce a number of resources to support staff undertaking projects e.g. newsletters, slides for feedback of results, regional conferences to enable discussion of results and sharing of good practice, networking opportunities, templates for local action plans, templates for strategies, and policies. Audit professionals and clinical staff should be encouraged to make best use of these.

New national audits or those planning changes to the content of the original data collection may run pilots. Where feasible, trusts should participate in these pilots as they can make staff feel they have some ownership of the project and can influence the content. Subsequently staff are more engaged and motivated to introduce changes in practice.

5.8 Monitoring change

It is important to ensure that identified actions and quality improvements are implemented, i.e. “closing the loop”. Monitoring of progress in implementing change needs to take place at both operational and strategic levels.

Initially the stakeholder group should plan regular reviews of the action plan to monitor progress. The leads for each action must report delays and/or problems in implementing the recommendations and with the support of the stakeholder group look for alternative solutions.

Clinical governance arrangements should be in place for the routine monitoring of progress with national audit which includes implementation of change. This may be done by reporting regularly to a trust clinical audit/effectiveness committee or clinical governance/healthcare governance group.

An organisation needs to have in place guidance or a policy on steps to take when results indicate that change is necessary and has not been implemented. There should be clear and transparent escalation routes e.g. to clinical director, chief nurse, medical director, healthcare governance and finally the board. It should include the level of risk to patients, staff and the organisation if no action is taken.

An example of a monitoring and escalation tool is a healthcare governance tool such as a dashboard. See *Clinical Audit Programme Guidance Tools* available from HQIP which tracks progress for each individual national audit on a quarterly basis via a traffic light system. This includes criteria for what constitutes an amber or a red score with clear instructions for escalation when adequate progress is not being made.

5.9 Requirement for re-audit and additional audit

It can be useful in the interim before the next round of national audit, to undertake locally a re-audit of those standards, which were found to have poor compliance, or with compliance below national average. This will provide assurance that any changes implemented have actually led to improvements in care. A further round of national audit will then hopefully show sustained improvements.

National audit results may also indicate that further audit needs to be undertaken on a related aspect of care.

Good practice example

An approach to improve implementation of national audit recommendations

At University Hospital Coventry, executive leads already sign-off all data before they are submitted and they receive executive summaries including local analysis. This gives them the opportunity to question and validate data before submission (and of course be made aware early of any potential concerns).

They are currently trialling the inclusion of an executive lead to drive actions for one national action plan. This executive lead is an executive director (probably either nursing or medical director). They will:

- be made aware of the projects/studies and their importance
- offer support when there is no response with either provision of data or actions when report is published.

5.10 Business planning

National audit findings can help to provide evidence to support business cases. The UK IBD Audit showed a large variation in the number of clinical nurse specialists employed by trusts per number of IBD cases. Trusts have used this information to obtain funding to appoint additional specialist IBD nurses. The National Clinical Audit of Falls and Bone Health in Older People has led to trusts developing successful business cases to support management of osteoporosis in primary care, appoint a Falls Coordinator, a Falls Specialist to cover care homes and additional rehabilitation assistants to undertake falls prevention work.¹¹

5.11 Service development and redesign

Organisational audit, clinical audit and patient survey results should all be used in the development or redesign of services.

"I think that the results can be used to support bids for service development if areas of concern are identified."

Trust Clinical Lead, National Falls and Bone Health Audit

Stroke services are being redesigned by trusts in line with the National Stroke Strategy with one of the main drivers being the National Sentinel Stroke Audit. The National Audit of Services for Multiple Sclerosis included a patient survey component, the results of which informed trusts on how their services needed to develop.

5.12 Inform commissioning process

"The next few years are going to be amongst the most challenging in the NHS for both commissioners and providers and innovation provides one of the mechanisms to meet these challenges. Audit has a central role in underpinning innovation offering rigorous data including that on patient experience." William Gray, Strategy Manager Specialised Services, NHS Sheffield

NHS commissioning and provider organisations should consider the contribution that national clinical audit can make to commissioning practice by providing evidence of the quality of care and the patient perspective on services. This is supported by a number of documents including *Commissioning a Patient-led NHS*¹² which outlines a healthcare commissioner's responsibility for safe and high quality services, *High Quality Care for All, The NHS Next Stage Review*⁹ which outlines commissioning for quality as a priority, *NHS Operating Framework 2008/09–2010/11*,¹³ *World Class Commissioning*¹⁴ which describes commissioning competencies that include responsibilities to lead continuous and meaningful engagement with clinicians to drive up quality, demonstrate quality improvement and outcomes.

National audits should have been prioritised as part of the commissioned annual clinical audit programme (See *Clinical Audit and Commissioning* available from HQIP) making results available for commissioners. These may be used in a variety of ways to:

- provide evidence of quality of care
- provide a patient view of current services and for future services
- feed into reviews of services to influence the future direction of services/service models
- provide information for re-commissioning
- assist in furthering the local delivery planning process
- confirm value for money.

An example of a useful results format to inform commissioning is the key indicators of care provided in some audits managed by the Clinical Effectiveness and Evaluation Unit, RCP. Key indicators of care are a subset of standards selected to best represent the total clinical process. Using results to inform commissioning may also mean that trusts will put a greater value on national audit work.

Commissioners and providers should also consider innovative uses for the combination of results from national organisational audit, clinical audit and patient surveys on a specific topic e.g. multiple sclerosis for service redesign.

5.13 Quality assurance

National audit findings can provide assurance that evidence based best practice is being undertaken in line with NICE, other national guidance, National Service Frameworks, national strategies, etc.

These data allow organisations to benchmark i.e. measure their performance against a standard reached by others. This could be against the top score or the national average.

“The national audit allows us to benchmark our activity and get insight into how we can best improve matters.”

Trust Clinical Lead, National Audit of Continence Care

One of the key points in *The next leg of the journey: How do we make High Quality Care for All a reality?* states that: *“Evidence from high performing health systems highlights the value of using information on comparative performance to bring about improvements in care, with the focus being on clinical quality. Transparency of information on variations in clinical quality should be used as part of performance management and to inform the public about the standards of care being achieved by NHS organisations to enable the aims of High Quality Care for All to be taken forward.”*⁸

6 Useful Information

*“Successful methods for supporting change should be shared.”*¹

The National Clinical Audit Forum (NCAF) was set up by HQIP in July 2009 to be an online resource for sharing best practice, exchanging views, gaining insights and developing audit practice. The forum provides an opportunity for all those engaged in national audit work to make suggestions for improvements and share solutions to problems.

6.1 Example of good practice

Benefits of participation in National Neonatal Audit Programme

“We have gained significant benefits from contributing to the National Neonatal Audit Programme. We contribute prospective clinical data on every patient admitted to the neonatal unit. The programme is web-based and we receive quarterly and annual reports on our performance, benchmarked against all other units offering the same clinical service. With the receipt of each quarterly report, I make a local summary and disseminate this widely. I identify one target for each professional group of workers to prioritise and improve upon. Thus I identify one area for obstetric/midwifery improvement, one area for neonatal nursing and one for neonatal medical staff each quarter. Some of these have resulted directly in changes in practice. Others have precipitated more detailed audits. We have developed a continuous improvement programme based on the national audit data that we receive.”

“The key elements to the programme which I feel make it particularly successful are as follows:

- *The web-based database is extremely easy to use. It was privately developed and each unit has contributed a relatively small amount of funds to be a member of the programme. In return for entering the clinical data, the tool delivers practical help for the neonatal service — it generates admission and discharge summaries, coding and billing data as well as accurate workload data that can now be used by us and our local commissioners. This means we not only get a return of the audit data but a significant management and clinical tool. For this reason data compliance is 100%.*
- *It is extremely important that we are benchmarked against other units and also extremely helpful that the programme is ongoing, i.e. we receive a quarterly update as well as an annual review of progress.*
- *There is excellent quality control inbuilt in the programme so that all missing data are regularly flagged up and identified early — there is no retrospective chasing of data which not only means data collection happens effectively but also that the data are reliable.*
- *The system is so easy to use that a wide range of personnel from administrative and reception staff, neonatal nursing and medical staff were easily trained to input data.*

“The specific examples of improvements from our last quarterly report showed that we had previously been identified as below average for administration of antenatal steroids. Following re-audit and re-launching our local policy, this has significantly improved. We were also below average for the length of time that parents of babies admitted, waited before seeing a consultant. These data supported a review in job planning and an over increase in consultant time for the unit and we are now in the top quartile for this. Finally, we had been a lower performing unit for assessment of babies’ temperature on admission. Again this has been an area of clinical focus and has resulted in a significant improvement in performance by the neonatal nursing staff.”

“Each quarter we will continue to focus on a different area and are steadily seeing ourselves working our way up across the quartiles. In addition, our accuracy of data regarding our workload has significantly improved as well as the quality of discharge summaries and the timeliness of written communication.”

Dr Rebecca Mann, Consultant Paediatrician, Taunton and Somerset NHS Foundation Trust

References

1. Burgess, R (ed.) *New Principles for Best Practice in Clinical Audit*. Radcliffe; 2011.
2. Healthcare Quality Improvement Partnership. *National Audit*; 2009. Available at: www.hqip.org.uk/national-clinical-audit. Accessed 5 December 2008.
3. Iles V, Sutherland K. *Organizational Change, a Review by Healthcare Managers, Professionals and Researchers*. London: Service Delivery Organisation; 2001.
4. Baker R, Hearnshaw H, Robertson N. (editors). *Implementing Change with Clinical Audit*. Chichester: John Wiley; 1999.
5. Adlard S. *Change Management Toolkit. Navigating Change in the NHS*. Leicestershire, Northamptonshire and Rutland Strategic Health Authority; December 2005.
6. People Development Works. Available at: www.peopledevelopmentworks.com/index.html. Accessed 6 September 2009.
7. Berger A. Action on clinical audit: progress report. *BMJ* 1998;316:1893–94 and 317:880–81.
8. Department of Health. *High Quality Care for All. NHS Next Stage Review Final Report*. London: The Stationery Office; 2008.
9. Bevan H, Ham C, Plesk P. *The next leg of the journey: How do we make High Quality Care for All a reality?*; Warwick: NHS Institute for Innovation and Improvement; 2008.
10. Hysong SJ. Meta-analysis: audit and feedback features impact effectiveness on care quality. *Med Care* 2009;47(3):356–63.
11. Royal College of Physicians. *Achieving Change from National Audit. National Audit of Organisation of Services for Falls and Bone Health in Older People*. London: Clinical Effectiveness and Evaluation Unit, Royal College of Physicians; 2007.
12. Department of Health. *Commissioning a Patient-led NHS*. Dear Colleague Letter. London: Department of Health; 2005.
13. Department of Health. *The NHS in England: The operating framework for 2009/10*. London: Department of Health 2008.
14. Department of Health. *World Class Commissioning: Vision summary*. London: Department of Health; 2007.

Further reading

[NHS Constitution for England](#) London: Department of Health; January 2009

Care Quality Commission reviews in 2009/10, Consultation. London: Care Quality Commission; December 2008

World class commissioning. Available at: www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm.


Trust Assurance and Safety — The Regulations of Health Professionals in the 21st Century. London: The Stationery Office; February 2007.

Good Doctors, Safer Patients. London: Department of Health; 2006.

Morrell C, Harvey G. *The Clinical Audit Handbook*. London: Ballière Tindall; 1999.

Appendix 1. Change management information

The following table summarises some helpful literature.

Change information	Links
<p>How to change practice: understand, identify and overcome barriers to change</p> <p>This guide aims to help managers and clinicians influence changes in practice, following on from <i>How to put NICE guidance into practice</i> launched in December 2005. <i>How to change practice: Understand, identify and overcome barriers to change</i> provides practical suggestions based on evidence and experience to help get NICE guidance into practice. The guide is split into 3 parts:</p> <ul style="list-style-type: none"> • Part 1 discusses the types of barriers to change encountered in healthcare. • Part 2 offers practical suggestions for how to identify the barriers to changes in your organisation. • Part 3 shows how to overcome these barriers, and highlights potential levers to help people do this. <p>Real life examples are provided illustrating how the methods described have brought about positive changes in a range of situations.</p>	<p>www.nice.org.uk/usingguidance/barrierstochange.jsp</p>
<p>The NHS Institute for Innovation and Improvement have over 80 service improvement tools.</p> <p>A number of examples specific to change management have been included below.</p>	<p>www.institute.nhs.uk/index.php?option=com_quality_and_service_improvement_tools&Itemid=551.html</p> <p>These can also be accessed from the drop-down 'quick links' box on the homepage (Quality and Service Improvement Tools).</p>
<p>A Step-by-Step Guide to Tackling your Challenges</p> <p>To enable you to access and navigate the full range of products available from the NHS Institute, this guide highlights the most relevant products and tools to help you tackle the challenges you face. These range from core service improvement tools found in the <i>Quality and Service Improvement Handbook</i> (see below) that help you get the basics right, through to using some of the more comprehensive products and services that the NHS Institute has to offer.</p> 	<p>www.institute.nhs.uk/index.php?option=com_quality_and_service_improvement_tools&Itemid=551.html</p>

Key challenges you may be addressing:

- improvement skills
- engaging others
- improving access
- quality of service
- optimising capacity
- patient safety.

Quality and Service Improvement Handbook



A step-by-step guide with improvement tools for each stage of the journey including addressing the human dimensions of change for individuals and organisations. This is not an academic guide but simple and practical whilst remaining comprehensive. The contents are divided into two sections:

Section 1 — Project Management Guide

Section 2 — Quality Improvement Tools, which includes:

- project management
- identifying problems
- stakeholder and user involvement
- mapping the process
- measurement for improvement
- demand and capacity
- thinking creatively
- human dimensions of change

www.institute.nhs.uk/index.php?option=com_quality_and_service_improvement_tools-&Itemid=551.html

Sustainability Guide



The *Sustainability Guide* provides practical advice on how you might increase the likelihood of sustainability for your improvement initiative. The Sustainability Model is a diagnostic tool that is used to predict the likelihood of sustainability for your project and is critical to use before individuals/teams embark on a change improvement programme. It quickly assesses whether it might fail and what you need to put into place before you start to ensure its sustainability and success.

www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=document_product_info&products_id=290

NHS Institute for Innovation and Improvement

Have Impact at Work and Make Yourself Heard



Is there a change that you would like to make at work, but you are struggling to get heard? Using the simple structure of a story can help you to clearly identify your message and get yourself heard.

TheWholeStory, who run the NHS Live Speaking for Success workshops, believe that using their Story Map will help you to articulate and communicate your message with greater impact.

www.institute.nhs.uk/

Thinking Differently



This book will provide you with a range of practical approaches and tools that many NHS leaders and front-line teams have already used to fundamentally rethink pathways of care and service delivery.

NHS Institute for Innovation and Improvement
www.institute.nhs.uk/building_capability/-new_model_for_transforming_the_nhs/thinkin_g_diff
[erently_guide.html](http://www.institute.nhs.uk/building_capability/-new_model_for_transforming_the_nhs/thinkin_g_diff)
Thinking Differently
If you want to order a free copy quote
NHSITHINKDIFF001
Tel: 0870 066 2071

Improvement Leaders Guides



This group of guides focus on the people and culture that make up an organisation and their impact on improvement. They are about the people side of change.

The guides are for anyone who wants to improve some part of their service in terms of patient safety, experience or outcomes. They are not in-depth textbooks but collections of advice from those experienced in healthcare improvement and the tools and techniques they have found useful. There have been 13 titles available for some time on a variety of improvement related topics and now there are two new additional titles: *Sustainability and its Relationship with Spread and Action and Use of Technology to Improve Services*.

Overview of all Improvement Leaders Guides:

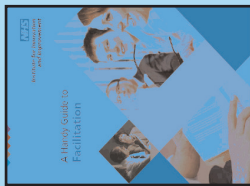
1. *General Improvement Skills*
2. *Process and Systems Thinking*
3. *Personal and Organisational Development*

http://www.institute.nhs.uk/building_capability/building_improvement_capability/improvement_leaders_guides%3A_introduction.html

Improvement Leaders' Guides

These 15 guides covering 3 themes are available as a boxed set and in electronic format. You can download them or order hard copies. They are free to anyone in the NHS England. If you already have a box of *Improvement Leaders' Guides*, you only need to order the additional two titles to go into your existing box. If however the *Improvement Leaders' Guides* are new to you, order the full-boxed set for all fifteen titles.

Facilitation Skills



These are an essential skill for change agents and often overlooked. Two guides have been produced to support facilitators. These were developed primarily for a day course.

NHS Institute for Innovation and Improvement
www.institute.nhs.uk/

NHS National Institute for Health Research (NIHR) Service Delivery and Organisation (SDO) programme

The SDO programme aims to make its research accessible to as many different audiences as possible. A range of products are used to publicise the work of the programme, including email bulletins and newsletters. One of its main aims is to improve understanding of the research literature and how to use research evidence.

They have produced the following three documents in relation to *Managing Change in the NHS* which are available to download:



Developing change management skills. A resource for health care professionals and managers.

This publication and web-based resource aims to help those leading change in health care to use the literature in this field to inform practice by:

- describing some of the relevant theories and approaches that have been used to guide change management
- illustrating the use of these theories in practice in a variety of settings in health
- encouraging readers to reflect on and evaluate change processes and how they might apply these to different settings.

www.sdo.lshtm.ac.uk/

SDO publications, including research summaries, briefing papers and resource documents are available in electronic format. Hard copies of most documents can be ordered for free.

www.sdo.nihr.ac.uk/managingchange.html
www.sdo.nihr.ac.uk/managingchange.html

Organisational Change: A review for health care managers, professionals and researchers



A review of models of change management to help managers, professionals and researchers find their way around the literature and consider the evidence available about different approaches to change.

Making Informed Decisions on Change: Key points for health care managers and professionals



A booklet, drawing on the review, which aims to encourage managers and professionals to reflect on and share what helps and hinders successful change to improve the quality of services

Further change information literature



Implementing Change with Clinical Audit

Baker R, Hearnshaw H, Robertson N. *Implementing Change With Clinical Audit*. Chichester: Wiley; 1999.

Bridges W. *Managing Transitions: Making the most of change*. 2nd edition. London: Nicholas Brearley, 2003.

Kerfoot K. Staff engagement: It starts with the leader. *Med Surg Nursing* 2008;17(1):64–65.

Schweiger D, Denisi A. Communicating with employees: a longitudinal field experiment. *Academy of Management Journal* 1991; 34:110–35.

Personality styles

Individuals react differently in the same situations.

Knowing how you interact may help overcome barriers to change when interacting with different personal styles.

Merrill DW, Reid RH. *Personal Styles and Effective Performance: Make your Style Work for You*. London: CRC Press; 1999.

Carnegie D. *How to Win Friends and Influence People*. London: Vermillion; 1953.

Appendix 2. Planning for data collection and entry (See An Information Governance Guide for Clinical Audit available from HQIP)

Data issues	Continuous data collection	'Snapshot' data collection
<p>Identify who will do the data collection</p> <p>Consider whether they have the required skills to obtain the data from patient records, databases, systems and provide training where necessary</p>	<p>Data collection may be undertaken by a combination of clinical, informatics and administration staff. Consider what works best in your organisation. Having data collectors/enterers who are staff members in the clinical area being audited enables any problems which may arise around the data collection process to be more easily resolved in-house.</p> <p>Plan for dedicated permanent staff so that continuous data collection is sustainable.</p> <p>Provide regular positive feedback to those undertaking data collection to sustain engagement and motivation.</p>	<p>Data collection by healthcare professionals working in the speciality of the topic being audited is the ideal. They have the clinical knowledge to extract data from patient records are more likely to instigate change in practice as a result.</p> <p>Data retrieval gives them ownership and first hand, instant awareness of problems with care or the recording of care. For example when a stroke MDT audited their multidisciplinary notes together for the National Sentinel Audit of Stroke this led to them changing practice before publication of results.</p> <p>Junior doctors should also be encouraged to be involved with data collection for national audit.</p>
<p>When will the data be collected and entered</p>	<p>Ensure staff are aware of continuous data collection requirements at the start of participation in a national project e.g. the data items, data collection period, submission date and report date. This impacts on when collection and entry take place.</p> <p>Encourage staff to do real time data collection rather than retrospective.</p> <p>Data entry should be as close to real time as possible. The sooner data are on the system the easier it is to keep track of patients to support data completeness. This means it is more likely to be an efficient process and lead to greater accuracy. It also provides the ability to feedback progress for early identification and resolution of any problems.</p>	<p>There will be a set time period for data collection, therefore it is important to provide staff with as much notice as possible so they can organise their work schedules appropriately.</p> <p>Some national audits provide information and access to their web-based tool earlier than the planned data collection period so take advantage of this.</p> <p>Try to pilot data collection with a couple of records to estimate time required per record so you can plan how many data collectors and how much time for auditing will be required.</p>

Data issues	Continuous data collection	'Snapshot' data collection
<p>How — what systems will need to be developed</p>	<p>Data collection is via a secure web-based system. It can be entered manually or by importing csv files. Data manuals with datasets and definitions are available on national audit supplier websites.</p> <p>Contact your Clinical Informatics Team/Information Manager to find out what databases/data capture systems are in existence and what data are already being collected in your organisation in relation to the audit topic.</p> <p>Where possible try to make use of any data collection systems that are currently in place. The ability to extract and use existing data will reduce the burden of data collection. However, remember data may seem the same but have been collected using different definitions to the national audit ones so may not be appropriate.</p> <p>If a new system is required, build around existing data capture systems. This can be done by using systems such as the Inflex Clinical Information System, a database which can be developed around clinical or specialty need and national data requirements e.g. national audit, MINAP, cancer waiting times. Build in benefits for clinicians which will make their lives easier e.g. automatically provides GP letters, MDT summaries. This will help to motivate the clinicians to stay engaged in data collection. The design of new systems is crucial to ensure data capture can be undertaken in the right place and at the right time e.g. Cancer MDTs.</p>	<p>No additional systems are required. Data can be entered straight from the patient record by clinical staff e.g. SpRs, clinical nurse specialists, therapists or entered onto a data collection proforma (provided by national audit supplier) by clinical staff and then entered onto web tool by administration staff.</p> <p>The majority of web-based tools developed for this type of national audit are user friendly e.g. those designed by the Clinical Effectiveness and Evaluation Unit, RCP.</p>

Data issues	Continuous data collection	'Snapshot' data collection
	<p>Plan to evaluate following the introduction of any new system to ensure it is fit for purpose. Electronic data entry may not be possible initially so you may need to develop a paper proforma for clinician use with data entry by administration staff. You should work towards the ideal of electronic data capture by the clinician.</p> <p>Monitor any new data collection system to ensure it is sustainable.</p>	
<p>How will patient sample be identified</p>	<p>As this is prospective data collection clinical staff may already have systems in place to identify patients who fit the inclusion criteria. It is important to do some cross checking with other patient lists e.g. Patient Administration System (PAS), Cancer Registry to ensure all appropriate patients have been included.</p> <p>It is important that any changes made as a result of audit findings are based on information from a full patient sample.</p>	<p>Codes are supplied to identify patients for inclusion. The sample can be identified from a number of sources: clinical coding, admission books, registers by diagnosis (e.g. stroke register). Due to coding issues the codes should not be used alone to identify the patient sample.</p> <p>Where consecutive admissions are required every effort should be made to find patient records so that data quality and completeness are not compromised.</p>
<p>Validation</p> <p>“Remember, you need to ensure as much accuracy, completeness and consistency of data as possible for it to be used effectively”</p> <p><i>Measurement for improvement, Improvement Leaders' Guide, NHS Modernisation Agency; 2005.</i></p>	<p>It is vital to establish a routine or cycle for validation. Run regular reports to identify any issues which require attention.</p> <p>The validation process should be consultant led. The lead clinician for the project may take on this role.</p> <p>This is a time consuming process but is balanced by the knowledge and assurance that the data for your organisation will be accurate before it goes into the public domain.</p>	<p>The lead clinician is responsible for validation. It is important to ensure all data collectors fully understand and interpret the data required in the same way to maintain consistency and accuracy.</p> <p>Encourage them to use the context specific online help of definitions and clarifications which are included in the web tools or the help booklets which are available. A telephone and email helpdesk are provided by national audit suppliers to answer individual queries.</p>

Data issues	Continuous data collection	'Snapshot' data collection
<p>Data submission</p>	<p>Although data are meant to be collected continuously there are specific submission dates for inclusion in national reports. For example the Head and Neck Cancer Audit collects data continuously but the final submission date is 20 November each year for inclusion in the annual report for patients treated between 1 November and 31 October.</p> <p>It is important to set systems in place so this actually happens or you will find staff will be disheartened by having to go back to collect retrospective data in order to catch up.</p> <p>Missing the submission date will mean that data for your organisation will be incomplete and will not appear in the national report for the time period.</p>	<p>Data collection often takes longer than anticipated as some patient records may be difficult to obtain e.g. patient being seen in outpatient clinic/readmitted.</p> <p>It is important to allow for this to ensure you meet submission date for the full patient sample.</p>

Appendix 3. Stage 4 – Making Improvements

Key points

A systematic approach to implementation appears to be more effective. Such an approach includes the identification of local barriers to change, the support of teamwork, and the use of a variety of specific methods.

An investigation of potential barriers to change assists in the development of implementation plans.

Teams undertaking audits that are appropriately supported and able to use a variety of techniques can identify potential barriers and develop practical implementation plans.

Contextual factors influence the likelihood of change. These include the significance of change to service users, the effectiveness of teamwork, and the organisational environment.

Those planning audits should avoid relying on feedback alone as the method of implementing change; although feedback of data alone can occasionally be effective, change is much more likely if it forms part of a more complex set of change processes/interventions.

The dissemination of educational materials, such as guidelines, has little effect unless accompanied by the use of selected implementation methods.

Interactive educational interventions including outreach, service user and/or professional reminders (whether manual or computerised), decision support, and system changes can sometimes, but not always, be effective.

In audit, the use of multifaceted interventions chosen to suit the particular circumstances is more likely to be effective in changing performance than the use of a single intervention alone.

Key note

Clinical governance programmes offer a structure to support efforts to make improvements, including personal professional development, support of teams, and clear accountability.

Reproduced from National Institute for Clinical Excellence. *Principles for Best Practice in Clinical Audit*. Abingdon: Radcliffe Medical Press; 2002, p. 47.