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Management Executive

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**Addressees:**

For Action:
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Health Boards
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For Information:

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Area Nursing Audit Committees
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Dear Colleague

GUIDANCE ON THE DEVELOPMENT OF CLINICAL AUDIT

**Summary**

1. This Circular gives guidance on the organisational changes required to support the continuing development of clinical audit within the Purchaser/Provider environment and provides information on the implementation of these changes and on future funding of audit.

2. Enclosed (Annex A) is an advance copy of a report by the CRAG Working Group on the Interface Between Clinical Audit and Management. This Circular sets out the action required to implement its recommendations which have been accepted in full.

**Action**

3. Health Boards should make arrangements to:

- set up the organisational arrangements necessary to support and sustain the evolution of multi-professional clinical audit and to prepare for including audit fully in contracts in 1994/95

- set up a multi-professional Area Clinical Audit Committee (ACAC) - to include professional, purchaser and provider unit representation - as soon as possible and not later than 30 September 1993

- ensure that the priorities for audit and the level of funding required are determined by mutual agreement between the Health Board and the Area Clinical Audit Committee (ACAC) in preparation for inclusion in contracts for 1994/95

- ensure that sufficient funds are earmarked to fund audit in Primary Care (Medical, Dental and Pharmacy) and for collaborative audit between Primary and Secondary/Tertiary Care and between separate provider units

- submit annual audit reports by 30 April 1993 and details of audit projects by 30 June 1993. See Annex B (Appendix 2)

4. Directly Managed Units and Trusts should:

- ensure that appropriate local arrangements for clinical audit are in place

- co-operate with the multi-professional Area Clinical Audit Committee in developing and implementing the area clinical audit strategy.

5. Further information is provided in Annex B.

6. Summary timetable:

| | |
|---|---|
| 30 April 1993 | Combined Annual Clinical Audit Report to be submitted to CRAG |
| 30 June 1993 | Details of local audit projects to be submitted to CRAG |
| 30 September 1993 | Area Clinical Audit Committee (ACAC) to be established |
| April 1994 | Arrangements in place to build audit into contracts. |

7. The advance copy of the Working Group's report may be freely copied. The report will be published in April 1993.

Yours sincerely

**W J FARQUHAR**
Secretary, CRAG

# GUIDANCE ON THE DEVELOPMENT OF CLINICAL AUDIT

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## 1. INTRODUCTION

**1.1** A Working Group was set up by the Clinical Resource and Audit Group (CRAG) in April 1992 under the Chairmanship of Sir Thomas J Thomson to give urgent attention to the interface between clinical audit and management, and between health care professionals and managers. The Working Group was given the following remit:-

> To examine the relationship between clinical audit and management, to make recommendations concerning the rights and obligations of both clinicians and managers in this area, and to comment upon any other relevant issues.

**1.2** The Working Group reported to CRAG in January 1993 and an advance copy of the final report is being issued with this circular. The report will be published in March 1993. This Circular offers guidance on the implementation of the recommendations set out in the report of the Working Group.

## 2. BACKGROUND

2.1 The development of contracts and the move to multi-professional clinical audit have implications for the organisation of clinical audit at local and national level.

2.2 Since the introduction of professional audit, funding has been ring-fenced and this arrangement will continue in 1993/94. However, revised arrangements will come into operation at the beginning of 1994/95 financial year. 1993/94 should therefore be regarded as a transitional year.

## 3. LOCAL ARRANGEMENTS

3.1 Area uni-professional audit committees should be replaced by a single multi-professional Area Clinical Audit Committee (ACAC) in each Health Board area which should be set up as soon as possible after 1 April 1993 and not later than 30 September 1993. While a Health Board is responsible for establishing and providing administrative support for the ACAC, this committee should be regarded as having an independent local function with a responsibility to purchasers, providers and to the Clinical Resource and Audit Group (CRAG).

3.2 It is intended that the ACAC should have a co-ordinating function and be able to take a strategic overview of audit within its area. For this reason representation should include, as far as possible, members representing local Purchasers (including GP Fundholders); local provider units (drawn from management and clinical staff); and all the major professional groups, including general practice. One of the most important recommendations of the Report of the Working Group is that managers should be involved in the process of audit as members of local audit committees. A single clinical audit committee with a mixed membership of health care professionals and managers will be well placed to define a local audit strategy, determine priorities for audit and ensure that a genuinely shared agenda develops. Further details of the suggested role and membership of ACACs are given in Box 7 of the Working Group's report.

3.3 Health Boards are asked to review the involvement of consumers in the process of audit within their area and:-

(a) to consider the inclusion of a consumer representative on the ACAC; and/or

(b) to ensure that ACACs establish close links with their local health council and other appropriate consumer groups.

3.4 The subcommittee structure and membership below the level of the ACAC is not prescribed given the diversity in scale and geography of the NHS in Scotland. However, it is anticipated that provider units, both directly managed units and trusts,

will wish to establish their own co-ordinating arrangements through a Unit Clinical Audit Committee (UCAC). However, the focal point for determining the area audit strategy will be the ACAC.

3.5 As audit becomes increasingly multi-professional in character existing uni-professional audit committees, although important in securing the establishment of audit, should be superseded by UCACs and by more focused inter-unit groupings of health care professionals working in a particular clinical field. There may be a continuing need for some work to be undertaken on a uni-professional basis and this is a matter for local decision. However, the strategic and funding functions of existing uni-professional audit committees will be undertaken by ACACs.

### 3.6 Supervision and Monitoring at Local Level

ACACs will have an important role in co-ordinating and overseeing audit within an area, but the detail of work and supervision of audit will fall to Unit/Trust Clinical Audit Committees and to Provider management where audit is specified as a contractual commitment. Purchasers will have responsibility for ensuring that a satisfactory system of clinical audit is in place in each unit and that audit projects specified in contracts are satisfactorily completed. Although health care professionals and managers have different roles to play in the audit process, they share a responsibility to ensure that the audit cycle is completed and that the results of audit are translated into improvements in patient care.

## 4. NATIONAL ARRANGEMENTS

4.1 The Clinical Resource and Audit Group (CRAG) has revised its own membership and subcommittee structure and will by September 1993 have established a single multi-professional Clinical Audit Subcommittee (CRAG-CAS) to replace the four separate uni-professional audit subcommittees. This will leave CRAG with two sub-committees: CRAG-CAS, to promote and monitor clinical audit, and the National Projects Committee (NPC), which will continue to fund and manage national audit projects.

4.2 CRAG will be inviting a representative of the Association of Scottish Local Health Councils to become a member.

### 4.3 Supervision and Monitoring at National Level

It is the responsibility of CRAG (as an adjunct to the Accountability Review process) to monitor the implementation and the general effectiveness of audit at local level. This will be carried out by a reporting process (ACACs will make annual reports to CRAG) and supplemented by visits.

5.3.2 Audit funds will be provided through the normal general health board allocations from 1994/95, through the weighted capitation arrangements. However, it is likely that an indicative level of expected spending on audit will be set to facilitate central monitoring of progress. Further guidance about this will be issued in Autumn 1993.

5.3.3 The Management Executive, in conjunction with providers and other appropriate bodies, will be responsible for determining the funding of clinical audit within centrally negotiated National Specialist Service Contracts.

## 6. AUDIT IN PRIMARY CARE

6.1 Health care professionals in primary care remain responsible for conducting and funding audit within their own practices. However, funding for collaborative audit - both between practices and between primary and secondary or tertiary care - will be made available at local level through the ACAC Audit Fund (see 5.2.4 above) and for national projects through CRAG. General practitioners should also have access to the services of audit facilitators.

6.2 In addition to carrying out their own audit activities general practitioners will wish to influence the audit activities carried out by local provider units. For this reason there should be primary care representation on both the ACAC and unit committees.

## 7. ANNUAL REPORTS OF AUDIT COMMITTEES

7.1 In previous years audit committees for medicine, nursing, pharmacy and dentistry have produced separate reports on their audit activities. From April 1993 health Boards are asked to submit a single combined annual report covering all audit activity. This report should be sent to the CRAG Secretariat by **30 April 1993.**

7.2 Guidance on the format and content of the 1992/93 Annual Report is included at Appendix 2. The format of the report is similar to previous reports except that details of local audit projects should be submitted separately by **30 June 1993.**

**CLINICAL AUDIT - ALLOCATIONS TO HEALTH BOARDS 1993/94**

| | |
|---|---|
| Argyll & Clyde | 297,800 |
| Ayrshire & Arran | 247,200 |
| Borders | 76,200 |
| Dumfries & Galloway | 126,000 |
| Fife | 244,400 |
| Forth Valley | 178,600 |
| Grampian | 344,700 |
| Greater Glasgow | 743,000 |
| Highland | 161,500 |
| Lanarkshire | 358,500 |
| Lothian | 525,900 |
| Tayside | 288,600 |
| Orkney | 25,000 |
| Shetland | 40,000 |
| Western Isles | 30,000 |
| CSA | 15,000 |
| State Hospital | 10,000 |
| Total | 3,712,400 |

**CLINICAL AUDIT COMMITTEE ANNUAL REPORT**

1. The report should be compiled jointly by the Area Clinical Audit Committee (or, if this committee has not yet been established, by the uni-professional Audit Committees) and the Health Board, each taking responsibility as indicated below for the separate sections of the report.

2. The Annual Report should encompass all developments from the completion of the most recent report up to 31 March 1993. Previous reporting periods ended as follows: Nursing - 31 December 1991; Medical - 31 March 1992; Dental and Pharmaceutical - 30 September 1992.

3. Health Boards are asked to ensure that annual reports are submitted to the CRAG Secretariat by **30 April 1993.**

4. Details of individual audit projects should be compiled separately and submitted to CRAG by **30 June 1993.** Further information regarding this exercise will be issued separately.

**FORMAT AND CONTENT OF ANNUAL REPORTS**

**A. REVIEW OF AUDIT ACTIVITY**
- separately from Committee Chairman and from Health Board Management.

* Brief overview of audit activity within all professions.

* Highlight and comment upon identified outcomes of audit, including improvements secured in quality of care and in use of resources.

* Area audit strategy for the year in question and the year ahead.

* Development of multi-professional clinical audit - current position and future prospects.

* Particular issues and difficulties arising, identifying those which CRAG might help to resolve.

* Areas identified as priorities for the coming year.

**B. AREA AUDIT COMMITTEE ACTIVITIES** - from Committee Chairmen

* Main meetings, workshops, seminars, conferences etc arranged and attended.

C. **STAFF INVOLVED IN AUDIT** - from Committee Chairmen

* Clinical staff involved in audit - a brief overview of the extent of audit activity within each specialty or profession, specifying where possible the percentage of staff actively participating in audit.

* Audit support and facilitation staff.

D. **FINANCIAL STATEMENT** - from Health Board Management.

* Summary of total resources employed during the period (specific allocations from SOHHD identified).

* Percentage of total Health Board revenue devoted to audit.

* Commentary upon this statement - by both Health Board Management and Area Audit Committee.