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National Health Service in Scotland
Management Executive

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Dear Colleague

A STRATEGIC FRAMEWORK FOR CLINICAL AUDIT IN SCOTLAND

Summary

1. The Strategic Framework for Clinical Audit in Scotland (attached) develops previous guidance on the aims, organisation and principles of clinical audit. In addition, a number of targets and objectives have been set covering strategy, multi-professional working and specialty and sectoral coverage.

Action

2. General Managers and Chief Executives should ensure that appropriate audit structures and strategies are in place in order to meet the requirements set out in the Strategic Framework for Clinical Audit.

3. General Managers and Chief Executives are asked to bring this document to the attention of the health professions at hospital, community and primary care level.

Yours sincerely

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A STRATEGIC FRAMEWORK FOR CLINICAL AUDIT IN SCOTLAND

CRAG

August 1995

INTRODUCTION

The Strategic Framework for Clinical Audit in Scotland was prepared by CRAG's Clinical Audit Subcommittee to set out the direction of clinical audit over the medium term. The Strategic Framework offers guidance on how clinical audit can play its part in improving the quality and effectiveness of clinical services. It also supports the work of the wider clinical effectiveness agenda (such as clinical guidelines and outcome indicators).

Health Boards are responsible and accountable for the delivery of the local clinical audit strategy. General Managers should consider how best to maintain the momentum of audit and maximise the opportunities which clinical audit presents. The key objectives to which clinical audit is expected to contribute are set out in the **Priorities and Planning Guidance 1996/97***(1)* and are summarised in the box below.

Box 1

PRIORITIES AND PLANNING GUIDANCE FOR THE NHS IN SCOTLAND 1996/97 (Extract, pp8-9)

Pursue Clinical Effectiveness, through development of clinical guidelines and protocols, and by the implementation of systematic clinical audit

Implementation of Common Core Work Programme for 1996/97 (which will be announced later in the summer) to guide and co-ordinate work of national bodies supporting improvement of clinical effectiveness.

Purchasers, Primary Care Practitioners and Providers to take action to implement clinical guidelines and good practice statements in a manageable number of locally agreed care areas.

Local clinical audit strategies and investment in clinical audit to reflect local purchasing and primary care strategies.

Health Boards to work with primary care practitioners on the implementation of clinical guidelines and programmes of audit.

Decisions about the deployment of resources for audit lie with Health Boards, in discussion with NHS Trusts and GPs. However, in allocating these resources and in the development of a local audit strategy CRAG sees Area Clinical Audit Committees (an advisory committee which brings together all the relevant constituencies) as the principal forum to facilitate and co-ordinate a coherent and consistent local approach to audit. This will provide a context for more detailed programmes of audit activity to be developed and implemented at Trust, clinical directorate or practice level.

The Strategic Framework for Clinical Audit is intended to consolidate and build upon earlier guidance *(see Annex B)*, principally Scottish Working Paper 2 which was issued in 1989. The five Fundamental Principles detailed in Working Paper 2 described the principles underpinning the Government's approach to medical audit in 1989. These principles were restated in the context of clinical audit in the Interface Between Clinical Audit and Management Report*(2)*. Five years on from the publication of the original Working Paper and with clinical audit now firmly established in practice, CRAG considered it appropriate to review the principles of audit in order to evaluate their relevance today.

The commitments of the original Fundamental Principles remain but the Strategic Framework seeks to build on them in order to clarify the longer term objectives for audit and to offer a more practical framework for the strategic development of clinical audit. The principles of clinical audit set out in this Strategic Framework, incorporating and developing those presented in the Working Paper, are outlined in the box below and presented in detail at Annex A.

Box 2

PRINCIPLES OF CLINICAL AUDIT

(1) An integral part of both the organisation and of everyday practice
(2) Professionally led
(3) An educational activity
(4) Confidential in respect of individual patients and practitioners
(5) Supporting overall organisational planning and service strategies
(6) Influenced by views of public and patients

Perhaps the most important 'new' message contained in this document is the explicit recognition that the introduction of clinical audit implies audit being undertaken by groups of health professionals who work together in the delivery of health care. These groupings or teams are likely to equate to professional management groupings within trusts (eg at directorate or sub-directorate/specialty level), or in the context of primary care at practice level. It therefore is crucial that these groupings have a clear view of their clinical audit programme and the way in which this audit programme supports the care they provide.

Audit in primary care and in the community services has been more difficult to set in train for a variety of reasons and, in consequence, is less well developed here than in the hospital services. Health boards and ACACs should take steps, through the provision of appropriate resources, to assist the development of clinical audit within these areas.

The definition of Clinical Audit is "the systematic and critical analysis of the quality of clinical care. This includes the procedures used for diagnosis and treatment, the associated use of resources and the effect of care on the outcome and quality of life

for the patient *(3)*". It remains important to stress that clinical audit should not be a self-contained academic exercise but must contribute to the goals of improving health and improving care. The aim of clinical audit in its widest sense is to contribute to improving health by supporting the delivery of high quality health care. The focus and value of clinical audit is to maintain and where necessary improve clinical quality.

The importance of managing the implementation of change is of course relevant to the NHS as whole, but it is particularly pertinent to clinical audit because by definition audit seeks to identify areas where practice can be improved and standards raised. At times the results of clinical audit will demonstrate that a clinical service is of a high standard and that the current quality of the service should be maintained and perhaps highlighted as an example of good practice. At other times clinical audit will identify where there is scope to improve a service. It may be possible to make improvements without additional resources, and sometimes improvements may result in more efficient and effective procedures resulting in lower costs either in the short or longer term, although it is likely that people will need support and time to make and sustain changes to their practice. However, it is clear that there will be occasions when changes identified by clinical audit will require more, or at least a reallocation of resources. There is therefore a need to acknowledge the limitations of clinical audit - that although audit can identify that changes are required, there is a need for commitment by both health care professionals and managers to enable such audit findings to produce lasting gains.

The Strategic Framework does not set out national priorities in terms of specific clinical topics for action; determining local priorities is a matter for agreement between all the relevant local stakeholders. However, all those considering audit proposals should take account of the three national priority areas - mental health, cancer and cardio/cerebro vascular disease - set out in the Priorities and Planning Guidance 1996/97 and also be aware of the topics which have been highlighted for attention as part of the Common Core Work Programme.

1 Priorities and Planning Guidance for the NHS in Scotland 1996/97 - MEL(1995)51
2 The Interface Between Clinical Audit and Management (the 'Thomson Report'), May 1993
3 The Interface Between Clinical Audit and Management (page 9)

A STRATEGIC FRAMEWORK FOR CLINICAL AUDIT IN SCOTLAND

PURPOSE

The main purpose is to improve the effectiveness and outcomes of care within the NHS by ensuring that clinical audit becomes an integral part of everyday clinical practice and evidence based guidelines and standards developed by the professions are made available to and utilised by healthcare professionals.

AIMS

- To ensure that all purchasers and providers have in place audit strategies which support the aims of national policies and the organisations' other strategies and business plans.
- To promote the move to multi-professional clinical audit.
- To ensure the clinical work of health care professionals in all sectors of the NHS is being supported by a programme of audit.
- To ensure appropriate standards are available to assist care providers in improving the effectiveness and outcomes of care.
- To ensure that suitable mechanisms are in place to allow standards and guidelines to contribute fully to improving the effectiveness of care.

OBJECTIVES

The key objectives underpinning the Aims are as follows:

1. Strategy

- An area audit strategy should be agreed and implemented by January 1996.
- The area audit strategy should be consonant with strategies at other levels and underpin the Board/Trusts business plans.

- There is a need for a co-ordinating mechanism at local level to link the activities of all bodies dealing with clinical quality issues, to provide a forum for discussion and prioritisation of relevant topics. Area Clinical Audit Committees (ACACs) are seen as the body providing this co-ordinating mechanism.

- The strategy should address the provision of an appropriate infrastructure (including audit staff and Information Management and Technology) to support audit.

- The strategy should address how clinical guidelines and clinical outcome indicators are to be handled locally.

2. The Move to Clinical Audit

- Audit should be increasingly undertaken on a multi-professional basis. Over half of all audit projects to be multi-professional by January 1998.

3. Specialty and Sectoral Coverage

- A rolling programme of clinical audit topics should be in place in all clinical directorates or subdirectorates (or the equivalent within non-acute sector) by January 1997.

- All specialties to be involved in audit.

- The programme of audit involving all those working in the primary care field should be increased. Health Boards should consider mechanisms for assisting the development of clinical audit amongst all health care professionals working in a primary care setting. This could be through increasing the provision of audit facilitators/assistants.

- All General Medical Training Practices to have a rolling programme of audit in place by January 1997.

- Two thirds of General Medical Practices to have a rolling programme of audit in place by January 1998.

4. Reinforcing the Principles of Audit

The key principles underpinning audit should be addressed within the audit strategies developed by Boards and providers *(see Annex A)*.

PRINCIPLES OF CLINICAL AUDIT

(1) AN INTEGRAL PART OF BOTH THE ORGANISATION AND OF EVERYDAY PRACTICE

1.1 Clinical audit activity should be focused on groupings of health professionals who work together for a common purpose and should support the clinical services they provide.

Each grouping of health professionals should have in place a programme of audit activity relevant and appropriate to the patients for whose clinical care they are responsible.

The size and composition of these groupings is not defined here as it will vary according to local circumstances but may comprise a clinical team in a ward or specialty or a clinical directorate or subdirectorate in a Trust hospital or a primary care team in general practice. It will in most cases equate to pre-existing clinical teams or sub-units of management. In addition, audit encompassing primary and secondary care and between Trust hospitals and general practices is to be encouraged.

1.2 Clinical audit should form part of everyday clinical practice within a culture of constant evaluation.

The work of each part of the service should be supported by an audit strategy which reflects and underpins its activities and is co-ordinated with the strategies of associated or related parts of the service. This strategy should be regularly reviewed to ensure that it both influences and is influenced by changes in the delivery of clinical care.

Realising this objective will require not only the commitment of individual health professionals but also a supportive organisation which empowers and enables staff to critically evaluate the decisions they take. This will involve also the provision of an audit infrastructure (eg audit support staff) and training (eg in audit methodology and epidemiological skills) which supports health care professionals in examining their own performance. Less tangible but perhaps more important in enabling clinical audit to become part of the service culture are good communications and co-ordination of clinical audit activity and internal trust, co-operation and collaboration in undertaking clinical audit.

The importance of this objective is increasingly being recognised. For example, the General Medical Council has introduced "Good Medical Practice" guidance which makes clear that doctors should work with their colleagues to monitor and improve the quality of health care and, in particular should take part in regular and systematic clinical audit.

The important relationship of clinical audit with research and development needs to be fostered. Health care research is about extending the body of knowledge of best practice; audit is about measuring whether best practice is being applied. While in theory audit and research are separate disciplines, in practice there is likely to be common ground with scope for productive co-operation.

1.3 The multi-professional working environment in the NHS implies that audit activity should also generally take place on a multi-professional basis, but with the opportunity for uni-professional audit, where relevant.

The identification of aspects of care warranting audit should be considered within a multi-professional context and where possible and appropriate audits should be undertaken on a multi-professional basis.

Clinical audit provides opportunities for team building and multi-professional working. It is likely that in most instances, the aspects of care identified for clinical audit will encompass the work of a number of professional groups and therefore lend itself to a multi-professional approach. Furthermore, many quality of clinical care issues lie at the interface between professions and a multi-professional approach is more likely to be able to identify and secure co-ordinated change where necessary.

Nevertheless, it is acknowledged that some clinical audit activity may, quite appropriately, have a narrow focus (eg a surgical procedure, or the response time of a particular service) and these would involve a single profession. It is also recognised that not only do different professions have different professional responsibilities and development needs, but for most people as they become more confident about undertaking audit within their own sphere, they become involved in multi-professional audit. Both multi-professional and uni-professional audit have legitimate and important roles to play.

1.4 The findings of clinical audit should inform clinical practice and management decision-making.

The primary function of clinical audit is to enable professionals to evaluate and improve the quality of the services they provide.

The output of the clinical audit process must be appropriately interpreted, reported, disseminated and used in order to inform clinical practice by providing informed definitions and explanations of existing standards of care and allowing any deficiencies to be identified. The benefits of audit will be maximised where there is co-operation and collaboration in the dissemination of the findings (both methodology and results).

The dissemination of information and good practice should be viewed as an important task at all levels - at national level CRAG and the Scottish Clinical Audit Resource Centre have a particular role in disseminating the results of national audit projects; ACACs and GP audit subcommittees should encourage and facilitate the dissemin-

ation of audit findings throughout the health board area; and audit committees within Trusts need to foster local networks to share good practice.

Clinical audit has the capacity to provide information which will allow more explicit and rational decision-making thereby ensuring that clinical services purchased and provided are as effective and efficient as possible. Monitoring of the audit process by Purchasers should concentrate on ensuring that Providers are effectively monitoring their own activity through local programmes of audit which underpin the local audit strategy.

1.5 Clinical audit should be an integral part of local quality assurance initiatives.

Health services need to address all three components of quality - quality of service, quality of clinical care and quality of life. All the initiatives and efforts directed at maintaining and improving quality should be co-ordinated to minimise duplication and maximise benefit to patients. This requires an explicit policy to co-ordinate (and where appropriate integrate) with other quality initiatives and structures concerned with quality improvement (eg quality assurance committees, infection control committees) at all appropriate levels in the organisation.

Clinical audit is an important means of developing and assessing clinical guidelines and their associated local protocols. These, in turn, are important measures for reducing inappropriate variation and encouraging the consistent application of best practice. Systematic evaluation of the quality of care is part of the provision of an environment in which actual processes and outcomes of care are known. As such clinical audit is an aspect of clinical risk management. Discussion of audit results should lead also to improved knowledge and understanding about the outcome of clinical care. Such information on outcome provides an objective means of assessing the effect of the process of care.

(2) PROFESSIONALLY LED

2.1 The audit process should be professionally driven.

2.2 The purpose and arrangements for clinical audit should be clear to all those with a part to play, including managers.

There needs to be leadership and commitment to support the audit process by both health professionals and managers in terms of defining the priorities for the audit programme and in implementing change. Securing change to clinical practice may require the support and involvement of management (eg in relation to resource allocation); the application of that change in practice is a professional matter depending directly on the patient/health professional relationship.

Participation in audit and implementation of any necessary action resulting from audit is more likely when those involved have ownership, commitment and motivation.

Local health professionals need to have a clear view of how audit can contribute to the care they provide and to be in a position to drive that process.

Leadership of individual multi-professional audit projects is a matter for local determination. It should be open to any of the professions involved to lead an audit, the leader being chosen on the basis of the issue being audited, the particular local situation and which profession is the major contributor to the process being audited.

2.3 Where necessary, management must be able to initiate an independent audit. This may take the form of external peer review or a joint professional and managerial appraisal of a particular service.

This provision was included within the 1989 Scottish Working Paper 2. Management has the right and the responsibility to indicate areas where they consider that audit would be appropriate. Experience to date has been one of increasing co-operation between professionals and managers in terms of agreeing where audit activity should be prioritised.

(3) AN EDUCATIONAL ACTIVITY

3.1 Clinical audit activity should form part of continuing professional education and development for all groups of health professionals.

3.2 The concept of audit and its contribution to health care should be introduced at pre-qualification level.

Clinical audit, while it can influence directly health care, essentially forms part of an educational process through which it brings about its effect. It must be linked together with existing arrangements for professional education, training and development.

(4) CONFIDENTIAL IN RESPECT OF INDIVIDUAL PATIENTS AND PRACTITIONERS

4.1 The Code of Confidentiality of Personal Health Information and associated guidance issued to the NHS in Scotland must be observed.

4.2 Health professionals should have sufficient confidence in the process of audit to feel able to participate.

Patient confidentiality is sacrosanct. Arrangements must ensure that the Interim Guidelines on Confidentiality and Medical Audit are observed.

The confidentiality of clinical staff and hospitals is seen as important but must not take precedence over patient interests. Professional interpretation of clinical audit results is crucial as is the development of trust within the organisation.

The guidance on confidentiality and on reporting arrangements set out in the Thomson Report (page 20) and the Interim Guidelines on Confidentiality and Medical Audit should be followed.

(5) SUPPORTING OVERALL ORGANISATIONAL PLANNING AND SERVICE STRATEGIES

5.1 Clinical audit strategies should both reflect and be reflected in the arrangements for the delivery of clinical care by the organisation.

Strategies will be formulated at a number of levels - national, Purchaser, Trust and clinical directorate level. Audit strategies and audit programmes also need to be developed and implemented in these settings. Audit activity should complement and support the goals and priorities of the organisation as defined in the appropriate strategy (ie the audit programme of a clinical directorate should be consonant with the Trust business plan which should itself reflect the Purchasing Strategy).

Various parts of the organisation are involved in the process: at national level a forum (currently CRAG) monitors and supports the development of clinical audit and provides guidance and ensures integration with national priorities and other initiatives; at regional level a forum (ACAC) develops a local audit strategy, reviews clinical quality issues prior to discussion of contracts and promotes collaboration between hospital, community, general practice and other agencies; and at Trust/locality level a forum (eg TCAC) determines local priorities and standards. Beneath this level clinical directorates or other clinical groups will develop specific audit programmes. However, audit strategies will only produce results if they are realistic and are appropriately supported in terms of time and other resources.

There needs to be recognition that different approaches to audit may be required depending on the scope and type of service being reviewed (eg an area-wide examination of a service would require co-ordination by the ACAC; analysis of a clinical intervention might be best evaluated through a national audit project; ensuring service integration and effective inter-departmental collaboration would be carried out at Trust level).

5.2 Clinical audit strategies should include explicit criteria for the selection of topics for audit.

Since proposals for topics to audit - outlined in national programmes or suggested by front-line staff - are likely to exceed the resources available to undertake the work, there will be a need to set priorities. The criteria for the selection process should be made explicit. There needs to be choice and consensus in the identification of audit

topics and a recognition that different people have different legitimate priorities and expect different sorts of answers from audit. There should also be a realistic understanding of the timescales of audit. The ACAC is seen as the body best placed to mediate the selection of audit topics at area level.

As well as an emphasis on individual patient care, audit strategies need a population perspective in order to address issues of efficiency, accessibility and equity.

5.3 Clinical audit projects should be completed, reported and evaluated in order to demonstrate results in terms of improved (or affirmed) quality of clinical care and value for money.

Clinical audit has in the past been criticised for failing to provide evidence that audit activity is producing benefits commensurate with the investment. In developing and carrying out audit projects there should be an evaluation of the process in order to quantify and document the outcomes of the work. There should be greater emphasis on quantifying the effects of audit activity both in terms of benefits to patients and value for money.

5.4 Clinical audit should inform the purchasing process by addressing and reporting on the quality of clinical care.

Aggregated and appropriately interpreted audit results should be used in contract monitoring. However, the importance of professional interpretation of audit results is stressed because in very many cases no direct inferences about the quality of care can be drawn from the results, rather such results will highlight issues which may require further investigation.

The potential of clinical audit to inform purchasing also needs to be seen within the context of the fact that the efficacy of many treatments is uncertain. This uncertainty should be reduced by the increasing development and use of evidence-based clinical guidelines as an authoritative standard against which to evaluate performance within the audit cycle.

5.5 Clinical audit strategies should encompass primary, secondary and tertiary care.

The audit process should recognise the spectrum of the patient's perception throughout the healthcare process. This will necessitate increasingly the establishment of audit activity across the administrative boundaries of care. The audit strategy should include therefore all settings of care, in particular care areas where different sectors interface.

5.6 Clinical audit strategies should be closely linked to strategies for the collection and use of clinical data.

Clinical audit should be supported by good quality clinical data. This means data which is relevant, accurate and complete. Good clinical summaries of episodes of care can assist this process and lead to the provision of precise and detailed morbidity coding. The ultimate aim is to make available for audit, information which properly reflects the clinicians' perception of the pathology, treatment and resources used for each episode of health care.

The requirements of clinical audit should be reflected in the Information Management and Technology (IM&T) strategies of both purchasers and providers.

(6) INFLUENCED BY THE VIEWS OF PUBLIC AND PATIENTS

6.1 The local clinical audit strategy should take into consideration the views of public and patients.

6.2 Health professionals should consider the patient perspective in the development of audit projects.

At a strategic level, audit programmes should be influenced by the views of public and patients and there should be representation of the local community on area clinical audit committees. At the level of individual audit projects, consideration should be given to including a systematic assessment of the views of patients and carers.

Health Boards should ensure that they have acted upon previous guidance (see MEL(1993)34) on the involvement of consumers in the process of audit.

FURTHER INFORMATION

I. PUBLICATIONS AND CIRCULARS

The following list of publications is not intended to be exhaustive, but it includes the major documents concerned with the development of clinical audit and/or related activities which have shaped national policies for the introduction of clinical audit in Scotland. (Published by CRAG except those marked *.)

1. Scottish Working Paper 2 - "Medical Audit" (February 1989)*
2. 1989(GEN)29 - "Guidance on Implementation of Medical Audit" (August 1989)
3. Confidentiality of Personal Health Information: Code of Practice (June 1990)* - issued with Circular No. 1990(GEN)22
4. Confidentiality and Medical Audit: Interim Guidelines (September 1990)
5. 1990(GEN)37 - "Guidance on Implementation of Nursing Audit" (October 1990)
6. MEL(1993)34 - "Guidance on the Development of Clinical Audit" (March 1993)
7. The Interface Between Clinical Audit and Management ('Thomson Report') (May 1993)
8. Clinical Guidelines Report (May 1993)
9. "Development of Clinical Audit - Additional Guidance" (Letter - 10 September 1993)
10. NAO Report - "Auditing Clinical Care in Scotland" (March 1994)* *(see also 12 and 15 below)*
11. MEL(1994)106 - "Priorities and Planning Guidance 1995/96" (November 1994)*
12. PAC Report - "Auditing Clinical Care in Scotland" (51st Report - HC 375) (December 1994)*
13. Clinical Outcome Indicators Report (December 1994) - issued with MEL(1994)82 - "Clinical Outcome Indicators"
14. Area Clinical Audit Committee - Annual Report 1994/95 (Letter - 19 December 1994)
15. "Treasury Minute on the Forty-ninth to Fifty-first Reports from the Committee of Public Accounts" *(Response to 12 above)* (February 1995)*
16. "Clinical and Cost Effectiveness in the NHS in Scotland: Consultation Paper on Roles and Relationships of the Main National Organisations Involved" - (14 February 1995)*
17. MEL(1995)51 - "Priorities and Planning Guidance 1996/97" (August 1995)*

II. ORGANISATIONS

The Clinical Resource and Audit Group (CRAG) is the organisation principally responsible for the introduction and development of clinical audit in Scotland. CRAG is funded by the Scottish Office Home and Health Department and is part of the Management Executive of the NHS in Scotland.

The main committee of CRAG meets four times per year and is chaired by the Chief Medical Officer. CRAG has three subcommittees - the Clinical Audit Subcommittee, the National Projects Committee and the Clinical Outcomes Working Group. In addition, three major organisations concerned with clinical audit and clinical guidelines are funded by CRAG.

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(B) CRAG-CAS - Clinical Audit Subcommittee

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(C) NPC - National Projects Committee

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(D) CR-OC - CRAG Clinical Outcomes Working Group

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(E) 'Moving to Audit' (Distance Learning Programme)

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(F) SCARC - Scottish Clinical Audit Resource Centre

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(G) SIGN - Scottish Intercollegiate Guidelines Network

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