

# How To: Involve Patients, Service Users & Carers in Clinical Audit

## INTRODUCTION

The aim of this 'How To' guide is to provide advice on how to involve patients, service users and carers in the clinical audit process. The Healthcare Quality Improvement Partnership (HQIP) state that the involvement and engagement of patients, service users and carers in clinical audit is vital and is a marker of high quality audit. If you are thinking about involving patients, service users and/or carers in your project it is important that you discuss this with your divisional Clinical Audit Facilitator at the planning stage. Aspects of this guide are discussed in more detail in:

- How To: Set an Audit Sample and Design your Data Collection & Data Collection Form.
- How To: Apply Ethics to Clinical Audit

## THE ENGAGEMENT AGENDA

The idea of public and patient engagement within the NHS is to enhance the quality of healthcare services by ensuring that they are oriented, planned and delivered to meet patient needs and interests. In particular, involving patients in clinical audit provides a mechanism by which NHS organisations can show that what is being measured actually matters to patients.

The Department of Health has published a range of guidance and legislation that places the engagement agenda at the heart of improving quality within the NHS, with the aim of ensuring that patient involvement is incorporated into the way in which NHS organisations make decisions and improve services. Key Department of Health documents are:

**“Clinical audit must include patients. They, as well as clinicians, are the true professionals in illness.** The doctor may be highly qualified to diagnose and give treatment. However, only the patients truly know the pain, physical and psychological, and the stress of their illness. The patient’s voice is so valuable as part of the audit”.

*Iain Thomas, MINAP representative, Member of the SW London Cardiac and Stroke Network HQIP, Patient & Public Engagement (PPE), PPE in Clinical Audit 2009*

- **Patient and Public Involvement in the New NHS (1999)** - This document places involvement at the centre of NHS policy, stating that health organisations “need to work with patients, service users, their carers and local communities to develop ways of improving health and making services and care responsive to individuals’ and local communities’ needs”.
- **Patient and Public Involvement Forums (PPIFs) (2003)** – A PPIF was established as an independent statutory body for each NHS trust and PCT in England. The aim of the PPIFs was to improve the quality of NHS services by representing the views and experiences of patients, their carers and families, through monitoring and reviewing NHS delivery, seeking the views of the public about those services and making recommendations to the NHS accordingly.
- **NHS Act, 2006** - Section 242 of the Act, states that all NHS organisations have a duty to involve by ensuring that arrangements are in place so that the ‘persons to whom those services are being or may be provided are, directly or through representatives, involved in and consulted on the planning of the provision of those services, the development and consideration of proposals for changes in the way those services are provided, and decisions to be made by that body affecting the operation of those services’.



- **Health and Social Care Act (2007) and Local Involvement Networks (LINKs)** - The Act reiterated that patient and public engagement should be part of the “core business” of every NHS organisation and replaced PPIFs with LINKs. LINKs are independently run by agencies or charitable groups with the aim of giving local citizens a voice and the authority to monitor local services and hold providers to account.
- **High Quality Care for All: NHS Next Stage Review (2008)** - Lord Darzi’s report emphasised the need for high quality care for patients and the public and the need to work in partnership. By stating that ‘measuring and valuing what matters most to patients, the public and staff is the way in which we will enable the NHS to make progress towards high quality care’.
- **World Class Commissioning (2009)** - World class commissioning aims to use best practice from across the world to help PCTs deliver better health and well-being for their population. Competency three states that this should mean to; ‘proactively build continuous and meaningful engagement with the public and patients to shape services and improve health’.
- **The NHS Constitution (2009)** - The NHS Constitution pledged that patients have the right to be involved in discussions and decisions about their healthcare, and to be given information to enable them to do this; and the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

**“The patient’s voice is so important but do not forget the carer. There are about six million voluntary carers, relatives and friends of all ages, in the UK. They have more experience than a doctor of a patient’s pain, problems and care needs. They are the unrecognised figures in dealing with patients, their views should be brought into the open through audit”.**

*Sirkka Thomas, Former Health Visitor and Cardiac Nurse, now carer for her husband  
HQIP, Patient & Public Engagement (PPE), PPE in Clinical Audit 2009*

## THE BENEFITS OF ENGAGEMENT IN CLINICAL AUDIT

HQIP states that ‘Patients need to be involved and engaged in the selection of initiatives to improve quality; in the governance of these initiatives, such as a clinical audit; in the collection of data for the audit; as part of the dissemination of the products to ensure, as consumers, they are provided with re-assurance and possible choice of healthcare provider, where such a choice is realistic or possible’.

*HQIP, Patient & Public Engagement (PPE), PPE in Clinical Audit 2009*

Clinical audit is about improving the quality of clinical services given to patients. At UHBristol we believe that clinical audit should be focused on what matters most to our patients, service users and their carers. For example, if outcomes are being audited, patients should be enabled to inform us about what outcome measures actually matter to them.

### THE BENEFITS

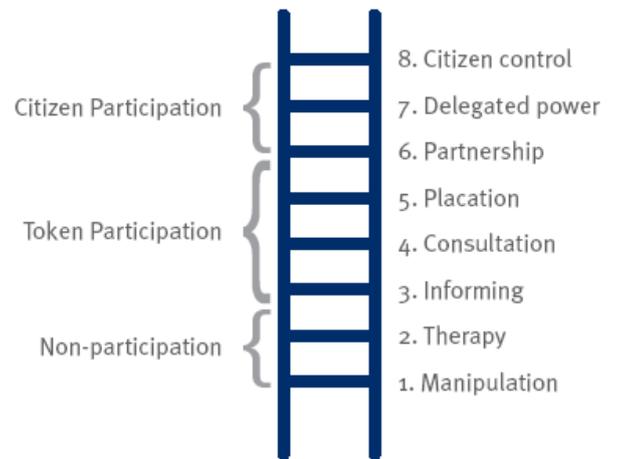
The benefits of engagement as specified below are based upon those listed by HQIP in Patient & Public Engagement (PPE), PPE in Clinical Audit 2009.

- Those who have lived with, or cared for, someone with a particular illness are “experts” in the condition. They have a subjective and valid view point based on actual experience about where quality could, and should, be improved.
- Through participation and engagement patients and service users can enhance clinical audit by achieving services better focused on their needs.
  - A patient’s or service user’s direct experience of care gives them a different perspective about ways to improve the quality of a service compared to a clinician. Patients might make different choices about which aspects of care should be included as standards to be measured through the clinical audit process.

- A patient can address the concerns they have raised by assisting with the development of the action plan. The patient’s perspective will provide staff with a clearer picture about what changes are needed and help to ensure that services are being provided in the way people want to see them.
- Clinical audit results can provide patients and the public with more knowledge about the quality of care in a particular healthcare setting; enabling them to make more informed choices about where they obtain treatment. Public reporting should raise public confidence in the NHS as it boosts trust and satisfaction. Involvement in clinical audit should also provide patients with a deeper insight into care that is provided. However, it is important to remember that the communication of audit results should be done in such a way to ensure it is accessible to the public and easy to understand, i.e. written simply whereby the data and conclusions are easy to understand.
- Being involved in improving the quality of care through the clinical audit process can bring health benefits to patients; feeling satisfaction after having influenced their care, being listened to, and from the social interaction and engagement that this offers.
- As a direct result of listening to local people and developing clinical audits that are responsive to local needs, patients and the public should feel a greater ownership of their local health services.
- Patient involvement will give clinical audit insight into the preferences of patients as to suitable indicators of the quality of care provided. It will further assist in the identification of what is needed to maintain and improve care in the future.

**METHODS OF INVOLVEMENT - THE THEORY**

In 1969, Sherry Arnstein developed her ‘ladder of participation’ concept to provide a framework for involvement. The ladder illustrates the different levels at which a patient/ service user may wish to participate and the level of involvement an organisation has reached.



The ladder is a useful visual tool and has been frequently adapted. Models commonly show information, consultation and partnership. In terms of clinical audit this might mean:

- Information – Informing patients of the results of a clinical audit. This is the lowest level of engagement.
- Consultation – Sending out a patient survey. This is often mistaken as a high level of involvement but is usually placed in the middle of the ladder and considered lower than engaging or partnering the patient.
- Partnership – Joint working between clinicians and patients, service users and careers to develop a clinical audit project from the very beginning, participating throughout the process and with potential for some clinical audit projects being patient-led. This is the highest level of engagement.

**HQIP CRITERIA AND INDICATORS OF BEST PRACTICE IN CLINICAL AUDIT**

The table below illustrates HQIP’s ‘Criteria and Indicators of Best Practice in Clinical Audit’. HQIP believe that a key element in achieving good quality clinical audit is through patient representation and participation. HQIP have adapted the NHS Centre for Involvement’s (NCI) set of six organisational standards and included additional criteria in order to give more in depth guidance for specific engagement in clinical audit.

CRITERIA	INDICATORS	HOW
Patients or their representatives are involved in the clinical audit if appropriate.	The patient group to whom the clinical audit standards apply is clearly defined.	
	The clinical audit standards take full account of patient priorities and patient-defined outcomes.	For example, the clinical audit incorporates Patient Related Outcome Measures (PROMS).



	Patients/carers are recognised as key stakeholders in the clinical audit process.	If appropriate and feasible, patient representatives and relevant patient organisations are involved in clinical audit governance, treated as stakeholders, and where appropriate, in all stages of the clinical audit cycle as equal members of the clinical audit team.
	Patients who are members of the clinical audit team are fully informed about what is expected from them in terms of participation, commitment and workload.	Not all patients and/or patient organisations will be members of the clinical audit team but, as relevant stakeholders, should still be kept informed and engaged.
	If required, patients who are members of the clinical audit team are given basic clinical audit training to enable them to contribute effectively to the clinical audit process.	
	Patients are kept informed throughout the clinical audit process about timescales, progress, results and actions.	All communications should use plain English avoiding the use of jargon and acronyms.

**METHODS OF INVOLVEMENT – IN PRACTICE**

Patients, service users and carers should not be involved in a clinical audit project simply as a tick-box exercise. At the outset of your project it is important to consider whether or not involvement will add value to your project design.

Most commonly, involvement in clinical audit is achieved through a survey; this is likely to be a questionnaire asking for details about what happened to the patient or service user. Surveys should only ask for information that cannot be collected from another source and that is related to processes or the outcomes of care, i.e. were standards of best practice being met. For instance, were they given the correct patient information leaflet?

Asking patients about their satisfaction with our services and/or their ideas for improvement is a valid and important aspect of patient involvement, but tends to sit outside the clinical audit cycle of measuring against standards.

Surveys are not the only means by which patients, service users and carers can be involved in clinical audit projects and programmes. Consider the following:

**GIVING INFORMATION**

Information can be made available locally to staff members, patients, service users and carers on planned clinical audit projects, current projects and completed projects. A summary can be provided outlining each clinical audit topic, the background, aims, objectives and standards; and in the case of completed projects a summary of the results and any actions implemented can also be included. This can be achieved via newsletters, leaflets or via posters located on the ward/ hospital notice boards.

If individuals have taken part in a survey, it is good practice to offer to send them a copy of the finalised report.



### GETTING INFORMATION

Information can be obtained from patients, service users, carers or members of the public via the following methods:

1. An area of concern raised by way of a complaint or via the Patient, Advice & Liaison Service (PALS) can be investigated using clinical audit.
2. A topic of concern highlighted via a focus group can be investigated using clinical audit.
3. Self-completed questionnaires – Questionnaires can be completed at the end of an episode of care.
4. Structured one-to-one interviews – Interviews can be face-to-face or via the telephone. The interviewer asks a number of pre-determined questions and allocates the answers to one of a pre-determined set of possible responses.

### FORUMS FOR DEBATE

Links can be developed with existing groups in order to give patients, service users and/or carers an opportunity to comment on your local clinical audit programme.

### PARTNERSHIP

Joint working between clinicians and patients, service users and carers can ensure that a partnership approach to clinical audit is instigated from the very beginning of a clinical audit process and continued throughout. There should also be some scope for some clinical audit projects to be patient-led.

Partnership working can be achieved through the involvement of patient, service user and/or carer representative(s) on your clinical audit committee or the clinical audit project team. This way, you could get direct input into:

- Identifying and prioritising topics.
- Designing projects.
- Setting process standards and key outcome measures.
- Collecting data.
- Analysing and interpreting results.
- Disseminating findings.
- Agreeing and monitoring action plans.

### EXCUSES FOR NOT INVOLVING PATIENTS

- One or two patients are not representative of all patients.
- Patients will not understand clinical audit.
- There are too many problems about confidentiality.

None of these problems are insurmountable. One or two patients on a committee may not be representative of all patients, but is this a good enough reason not to do it? After all, are the clinicians on your committee representative of all clinicians? Patients can be given basic training in audit. They can sign confidentiality undertakings. The real issues are about motivation, time and resources.

### CHECKLIST FOR INVOLVEMENT ON COMMITTEES / ON PROJECT TEAMS

- Try to find people who are used to committee/ project work. You could consult with patient organisations to help identify appropriate representatives.
- Try to ensure that the patients you involve have links to wider networks, for wider consultation.
- Do not select a current or former patient of a clinician who sits on your committee. This is unfair to both parties.
- Be clear about why you have involved patients and what you are hoping that they will contribute.
- Be clear about expectations.
- Provide training as appropriate.
- Ensure you can pay travel and carer costs.
- Schedule meetings at convenient times for patients.
- Think about physical access to meeting rooms.



- Avoid jargon.

## QUESTIONNAIRE, INTERVIEW & SURVEY GROUP

All structured surveys, staff or patient, administered by post, in hospital, or via a one-to-one interview, are subject to approval by the Questionnaire, Interview and Survey (QIS) Group. The QIS group offers advice on survey design and is responsible for monitoring all survey activity at the Trust. Please contact Paul Lewis, the Patient Involvement Facilitator for advice on structured surveys/ questionnaires. If you require advice on unstructured interviews and focus groups, this should be discussed directly with Tony Watkin, the Trust's Public Involvement Project Lead. The contact details for QIS, Paul Lewis, and Tony Watkin are listed at the end of this guide. Formal Research projects are subject to approval by a Research Ethics Committee (REC) and therefore do not require QIS approval.

## SUMMARY

In essence, the engagement of patients and public, both nationally and locally in clinical audit needs to involve:

- Engagement in the strategic direction of clinical audit.
- Consultation in respect of standards to be audited.
- Active participation in collection and analysis of clinical audit data.
- Engaging the public in communication activity about clinical audit, partly as patients or potential patients of treatment, and also through involvement in governance.

To achieve this, involvement needs to underpin the whole conception of clinical audit, from beginning to end. It needs to be integral to the whole project.

## FURTHER READING

"A guide to patient and public involvement in quality improvement", HQIP, 2016  
<http://www.hqip.org.uk/resources/patient-and-public-involvement-in-quality-improvement/>

## CONTACT DETAILS/ USEFUL INFORMATION

### CLINICAL AUDIT

- The UHBristol **Clinical Audit website** is available via <http://www.uhbristol.nhs.uk/for-clinicians/clinicalaudit/>
- Contact details for UHBristol **Clinical Audit Facilitators** are available via <http://www.uhbristol.nhs.uk/for-clinicians/clinicalaudit/contacts/>
- The full range of UHBristol Clinic Audit **'How To' guides** are available via <http://www.uhbristol.nhs.uk/for-clinicians/clinicalaudit/how-to-guides/>
- Copies of UHBristol **Clinical Audit Proposal Form, Presentation Template, Report Template, Summary Form, and Action Form** are available via <http://www.uhbristol.nhs.uk/for-clinicians/clinicalaudit/carrying-out-projects-at-uh-bristol/>
- The UHBristol **Clinical Audit & Effectiveness Central Office** can be contacted on 0117 342 3614 or e-mail: [stuart.metcalfe@uhbristol.nhs.uk](mailto:stuart.metcalfe@uhbristol.nhs.uk)
- **Clinical Audit Training Workshops** can be booked through the Clinical Audit & Effectiveness Central Office as above.

### CLINICAL EFFECTIVENESS

- For advice on **Clinical Effectiveness (NICE, NCEPOD, PROMS, guidelines)** matters contact Stuart Metcalfe, Clinical Audit & Effectiveness Manager, 0117 342 3614 or e-mail: [stuart.metcalfe@uhbristol.nhs.uk](mailto:stuart.metcalfe@uhbristol.nhs.uk)



#### PATIENT EXPERIENCE

- For advice on carrying out **surveys, interviews and questionnaires** please contact Paul Lewis, Patient Experience Lead (Surveys & Evaluations), 0117 342 3638 or e-mail: [paul.lewis@UHBristol.nhs.uk](mailto:paul.lewis@UHBristol.nhs.uk)
- For advice on conducting **qualitative and Patient Public Involvement Activities (focus groups, community engagement, co-design, workshops)** please contact Tony Watkin, Patient Experience Lead (Engagement & Involvement), 0117 342 3729 or e-mail: [tony.watkin@UHBristol.nhs.uk](mailto:tony.watkin@UHBristol.nhs.uk)
- All surveys that are being carried out for service evaluation or audit purposes should be discussed with Paul Lewis in the first instance. Patient experience surveys will also usually need to be approved by the Trust's **Questionnaire, Interview and Survey (QIS) Group**. Proposals should be submitted to Paul Lewis using the QIS proposal form. The proposal form and covering letter template is available via <http://www.uhbristol.nhs.uk/for-clinicians/patient-surveys,-interviews-and-focus-groups/>

#### RESEARCH

- For advice on research projects contact the **Research & Innovation Department** on 0117 342 0233 or e-mail: [research@UHBristol.nhs.uk](mailto:research@UHBristol.nhs.uk)
- Further information can be found via <http://www.uhbristol.nhs.uk/research-innovation/contact-us/>

#### LITERATURE REVIEWS/EVIDENCE

- For advice on literature reviews, NHS Evidence, article/book requests and critical appraisal contact the **Library and Information Service** on 0117 342 0105 or e-mail: [Library@UHBristol.nhs.uk](mailto:Library@UHBristol.nhs.uk)

#### SAMPLE SIZES

- The **Sample Size Calculator** is available via: <http://www.uhbristol.nhs.uk/for-clinicians/clinicalaudit/how-to-guides/>

#### QUALITY IMPROVEMENT

- Further information about clinical audit and wider quality improvement is available via the Healthcare Quality Improvement Partnership (HQIP) - <http://www.hqip.org.uk/>