**Clinical Audit Work Request & Registration Form**

**(Form to be completed when the audit is in addition to the agreed RDaSH Clinical Audit Work Programme)**

|  |  |  |
| --- | --- | --- |
| **Audit Title:** Please specify | | |
| **Audit Lead(s):** Please specify | | |
| **Titles(s):** Please specify | | |
| **Telephone No:** Please specify | | |
| **Email Address:** Please specify | | |
| **Service:** Please specify | | |
|  | | |
| **Care Group:** | | **Please indicate** |
| Children’s | |  |
| Doncaster | |  |
| North Lincolnshire | |  |
| Rotherham | |  |
|  | | |
| **Service:** | | **Please indicate** |
| Adult Community Mental Health | |  |
| Adult Inpatient Mental Health | |  |
| Children and Adolescents Mental Health Service (CAMHS) | |  |
| Children Young People & Families (CYP + F) | |  |
| Corporate Services | |  |
| Drug and Alcohol | |  |
| Forensic Services | |  |
| Learning Disabilities | |  |
| Medical/Pharmacy Services | |  |
| Older Peoples Community Mental Health | |  |
| Older Peoples Inpatient Mental Health | |  |
| Physical Health Community Services | |  |
| Physical Health Inpatient Services | |  |
|  | | |
| **Will this be a Trustwide or locality specific audit?** | | **Please indicate** |
| Trustwide | |  |
| Locality Specific | |  |
| Locality to be involved (Please specify) | | |
| ***If the project is not to be undertaken Trustwide (i.e. throughout all adult inpatients services), please indicate the reasons why:*** | | |
|  | | |
| **Type of Work:** | | **Please indicate** |
| Clinical Audit | |  |
| Clinical Effectiveness | |  |
|  | | |
| **Clinical Assurance Category:** | | **Please indicate** |
| Safety | |  |
| Patient Experience | |  |
| Effectiveness | |  |
| **Reason for the Audit:** | | **Please indicate** |
| National Audit | |  |
| CQC, state No: | |  |
| CQUIN | |  |
| NHSLA Risk M. Standards | |  |
| Identified on Risk Register | |  |
| Quality Marker | |  |
| Performance Indicators | |  |
| NICE Guidance, state No: | |  |
| Complaint/Incident | |  |
| Contractual/Commissioner Requirement | |  |
| Area of Concern | |  |
| Re-audit | |  |
| Other | |  |
| If other, please specify: | |  |
|  | | |
| **Main Aims/Objectives for the audit: (what do you want to achieve or assess?)** | | |
| **What criteria and standards** are you going to measure, i.e. what is the aspect of care that you are going to examine and what target are you going to set? | | |
| **Criteria Number** | **Criteria** | **Standard (%)** |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |
| ***Continue on separate sheet if necessary*** | | |
|  | | |
| **Audit Methodology:** | | **Please indicate** |
| Prospective | |  |
| Retrospective | |  |
| Concurrent | |  |
| Prevalence (held on one specific day) | |  |
|  | | |
| **Data Collection Method:** | | **Please indicate** |
| Data collection proforma | |  |
| Questionnaire | |  |
| Interview | |  |
| Other | |  |
| If other, please specify: | | |
|  | | |
| **Data source:** | | **Please indicate** |
| Patient records | |  |
| Computer held information | |  |
| Patient experience | |  |
| Staff experience | |  |
| Observation | |  |
| Other | |  |
| If other, please specify: | | |
|  | | |
|  | | |
| **Stakeholders:** | | **Please select** |
| Have key people been made aware of this audit (i.e. people who will be providing services covered by this audit)? | | Yes  No |
| ***It is essential that anyone who will be providing services covered by this audit are made aware of the audit at the start to ensure where any changes are required at the end that they fully understand why these are necessary.*** | | |
|  | | |
| **Timescales** | | **Please specify** |
| Please state the expected START date of the audit/project: | |  |
| Please state the expected COMPLETION date of the audit/project: | |  |
|  | | |
| **Clinical Audit Support:** | | **Please select** |
| Do you require any support from the Clinical Audit Team? | | Yes  No |
| If yes, please state the support required from the Clinical Audit Team: | | **Please indicate** |
| Advise on how to conduct the audit | |  |
| Data input | |  |
| Data analysis | |  |
| Typing of tables/graphs for presentation of results | |  |
| Support with completing the audit report | |  |
| Other | |  |
| If Other, Please Specify | | |

|  |  |  |
| --- | --- | --- |
| **PRIORITISATION SCORE SHEET**  Please complete the following prioritisation scoring sheet to establish the level of priority for the project. Following your submission of the work request form, the relevant Care Group will be notified on the monthly report. Projects scoring a medium/high will be considered for support. Projects scoring low will be considered a low priority and therefore, support from the Clinical Audit Team may not be approved.  **If you require any assistance in completing the work request form/prioritisation score sheet, please contact the department on 01302 796728.** | | |
| **Audit Title:** | **Score** | **Maximum Score** |
| **Reason for undertaking this audit project Max = 38** | | |
| **Compliance with national and local clinical priorities** |  | **Max = 11** |
| National clinical guidance e.g. NICE, New Horizons | 2 |  |
| Identified by the Care Quality Commission (CQC) Fundamental Standards for Healthcare | 2 |  |
| CQUIN | 2 |  |
| Commissioner Request/Requirement | 2 |  |
| Quality Marker/Performance Indicator | 2 |  |
| Local Care Group identified audit | 1 |  |
| **Management of risk** |  | **Max = 5** |
| Problem identified through clinical incident reporting/ significant event analysis | 1 |  |
| Problem identified through patient complaint/complaint monitoring | 1 |  |
| Topic identified through risk management process e.g. NHSLA | 1 |  |
| Issue identified through litigation/risk of litigation | 1 |  |
| Identified though the risk register | 1 |  |
| **Other** |  | **Max = 5** |
| Relates to strategic goals/objectives | 2 |  |
| Patient/carer feedback | 2 |  |
| Need for re-audit of previous topic | 1 |  |
| **Area of Clinical Practice** |  | **Max = 4** |
| One of high volume | 1 |  |
| One associated with high costs | 1 |  |
| One of concern (i.e. outcomes/practice could be improved | 1 |  |
| One where there has been a change in practice requiring evaluation | 1 |  |
| **Evidence based Guidelines/Standards** |  | **Max = 9** |
| NICE | 2 |  |
| CQC Standards | 2 |  |
| Royal College | 1 |  |
| Other Professional bodies | 1 |  |
| Policy | 1 |  |
| Locally developed clinical guidelines | 1 |  |
| Locally adopted clinical standards e.g. Essence of Care | 1 |  |
| **Involvement of agencies/disciplines/users** |  | **Max = 4** |
| Multi – Organisational e.g. GP’s | 2 |  |
| Multidisciplinary | 1 |  |
| Identification/development of audit topic by patient/carer | 1 |  |
| **Project Total (max = 38)** |  |  |

**Key: 0- 13 = Low 14-26 = Medium 27-39 = High**

|  |  |
| --- | --- |
| **Audit/Work Request Approval (s)** | **Please select** |
| Has this audit been discussed and approved by your Care Group | Yes  No |
| Has this audit been discussed and approved by your Governance Group | Yes  No |
| **Who has approved this audit?** |  |
| Care Group Director | Yes  No |
| Associate Nurse Director | Yes  No |
| Associate Medical Director | Yes  No |
| Consultant | Yes  No |
| Date Approved (please specify) |  |
| Name of Approver (please print name) |  |
| Signature of Approver | |

***Please return this form by post to:*** Clinical Audit Team

**CLINICAL AUDIT TEAM USE ONLY**:

Date received: / /

Date approved by The Clinical Quality Group: ….. / ….. / …..

Clinical Audit Facilitator: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Submission Year: \_\_\_\_\_\_\_\_\_\_\_

Chestnut View, Tickhill Road Site, Doncaster

**Or email:** [rdash.clinical-effectiveness-team@nhs.net](mailto:rdash.clinical-effectiveness-team@nhs.net)