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CLINICAL EFFECTIVENESS COMMITTEE STANDARD

Advice To Emergency Departments Regarding The Prioritisation Of Clinical Audit

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Introduction

Good clinical governance underpins high quality healthcare, and clinical audit is a key plank of clinical governance. With an increasing emphasis on quality and financial management in the NHS, Emergency Departments are faced with spiralling demands for accurate data, and are also expected to participate in an increasing number of local, regional and national audits. At the same time senior clinical staff are coming under pressure to devote more of their time to direct clinical care, and reductions in healthcare funding are anticipated. Whilst participation in clinical audit is known to be associated with good patient care and improved outcomes, it is simply not possible for every ED to participate in every audit initiative, and this advice has therefore been prepared in response to requests to offer guidance on audit prioritisation.

Advice To Emergency Departments

The College of Emergency Medicine supports ongoing clinical audit in all Emergency Departments (EDs), and recommends that all doctors of all grades participate in audit. This audit should be relevant to clinical care in Emergency Medicine, capable of achieving meaningful change and technically feasible. Audit should also be multidisciplinary, involving other emergency care professionals and those outside the ED where appropriate. The College recommends that requests to participate in clinical audit are prioritised as follows:

First Priority

- Mandatory national audits, for example the return of data to the Myocardial Infarction National Audit Project (MINAP) and the Trauma and Audit Research Network (TARN) where this is mandatory (e.g. for designated trauma centres). The collection of data for these audits should place minimal burden on ED clinical staff
- National audits conducted by the College of Emergency Medicine. The College operates a rolling national audit programme to support the delivery of high quality clinical care. This programme is determined by the College in consultation with national bodies, and provides direct evidence of effective participation in clinical governance. It is anticipated that participation in CEM national audits will also prove valuable in the revalidation process
- Local audit where specific clinical issues have been identified by ED staff.

Second Priority

- National audits with direct relevance to Emergency Medicine and national audit initiatives that have been formally endorsed by the College of Emergency Medicine should automatically be considered second priority or higher
- Audits required for local quality, performance or reimbursement purposes (e.g. those associated with Clinical Quality Indicators)
- Regional or local audits of particular value. Such projects will be identified locally, and will be prioritised according to their individual merits. They will usually be short duration audits with clearly defined objectives.

Third Priority

- National or regional audits of limited value to Emergency Medicine. Such audits will not have been endorsed by the College
- Local audit initiatives of limited relevance to Emergency Medicine, or with little prospect of achieving a meaningful change in practice.

It is recommended that as new audit initiatives arise they are prioritised according to the above scheme. All EDs should actively participate in first and second priority audits, and should also aim to participate in a limited number of priority three audits according to local resource and circumstances.

Further Comment

The College of Emergency Medicine will ensure that the demands of its own national audit programme and other audits endorsed by the College do not place an unreasonable demand on EDs. The College will also update this guidance following any major developments, for example the introduction of "Quality Accounts". However, good quality audit is only possible when dedicated time and support are provided by an Acute Hospital Trust, and contribution to clinical audit should be recognised in consultant job planning. If an ED can demonstrate clear difficulties in achieving all first and second priority audits the College would see this as a strong argument for the provision of additional resource.

Historically participation in clinical audit has been considered valuable training for junior doctors in Emergency Medicine, and this is sometimes used as a discriminator when doctors are applying for further training or Consultant posts. Whilst participation in audit can provide valuable educational opportunities, the performance of simple clerical tasks is of limited benefit. It is suggested that junior ED doctors are encouraged to contribute to ongoing national audits, but that basic clerical duties are undertaken by appropriately employed support staff.

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