

Ethical Audit at the Centre for Quality Improvement:

Ensuring that high ethical standards are applied to clinical audit

Summary

The Royal College of Psychiatrists' Centre for Quality Improvement (CQI) runs a series of national quality improvement programmes and networks. Participating trusts occasionally enquire about whether the subject and methods of data collection by these networks necessitates research ethics approval. The CQI collects data for the purpose of audit and occasionally, for the purpose of service evaluation with a view to service improvement; it does not undertake research. Neither clinical audit nor service evaluation, of the type undertaken by the CQI, require approval from a research ethics committee. However, the Centre is keen to underline its ongoing commitment to conducting its work in a responsible and ethical manner.

What is clinical audit?

"Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against each explicit criterion. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery".

Principles for Best Practice in Clinical Audit, National Institute of Clinical Excellence (2002)

Clinical Audit is directly related to improving services against a standard that has already been set by examining:

1. Whether or not what ought to be happening is happening
2. Whether current practice meets required standards
3. Whether current practice follows published guidelines
4. Whether clinical practice is applying the knowledge that has been gained through research
5. Whether current evidence is being applied in a given situation

Guidance on developing procedures within NHS organisations for appropriate authorisation and management of research and related projects, Research and Development Forum, 2005

Table 1 lists the features of research, audit and service evaluation. The table was devised by the Central Office for Research and Ethics Committees. COREC's position is that *"Audit and Service Evaluation, however defined, were recognised to have no, or less than minimal (risk), and there was broad agreement that such work need not come before an NHS REC, unless specifically requested"*

(COREC: ethics consultation e-group Audit, research or service evaluation, Oct 05)

Table 1: A table for researchers and reviewers to use and for the “queries line” to refer to.

| RESEARCH | CLINICAL AUDIT | SERVICE EVALUATION |
|--|---|--|
| Designed and conducted to generate new knowledge | Designed and conducted to provide new knowledge to provide best care | Designed and conducted to define current care |
| Quantitative research – designed to test an hypothesis Qualitative research - explores themes following established methodology | Designed to answer the question: “Does this service reach a predetermined standard?” | Designed to answer the question: “What standard does this service achieve?” |
| | Measures current service against a standard | Measures current service without reference to a standard |
| May involve a new treatment | Doesn't involve a new treatment | Doesn't involve a new treatment |
| May involve additional therapies, samples or investigations | Involves no more than administration of questionnaire or record analysis | Involves no more than administration of simple interview, questionnaire or record analysis |
| May involve allocation to treatment groups NOT chosen by HCP or patient | Does not involve allocation to treatment groups: the HCP and patients choose treatment | Does not involve allocation to treatment groups: the HCP and patients choose treatment |
| May involve randomisation | Does NOT involve randomisation | Does NOT involve randomisation |
| Under current guidance, research REQUIRES R.E.C. REVIEW | Under current guidance, audit DOES NOT REQUIRE R.E.C. REVIEW | Under current guidance, service evaluation DOES NOT REQUIRE R.E.C. REVIEW |

COREC ethics consultation e-group: Audit, research or service evaluation, Oct 05.

Discussions between the CQI and COREC

On the few occasions that the CQI has consulted ethics committees about its work, their response has confirmed our position. For example, in February 2006, the CQI submitted a description of the ‘Better Services for People who Self-Harm’ Project to COREC, detailing the audit methods used at the CQI, including staff and patient surveys and consultations, the auditing of case notes and conducting peer-reviews. The CQI also reiterated the safeguards it has put in place to protect the dignity, wellbeing and safety of participants throughout the audit process. The following reply was received from COREC:

"Thank you for your query. We have read the documents you attached and would deem your work to be audit. We agree entirely that audit should be conducted to accepted ethical standards and your document clearly outlines this".

(COREC February 2006).

A similar response was received when the CQI contacted the Welsh MREC about the Electroconvulsive Therapy Accreditation Service (ECTAS) in 2003.

The Centre for Quality Improvement and ethical audit

The Centre has been running quality improvement programmes since 1999 and now has ten quality improvement programmes underway (see table 2). All of the projects managed by the CQI meet the criteria listed in the 'clinical audit' column above and are therefore defined as audit, not research.

Table 2: Quality Improvement Clinical Audit Programmes managed by the Royal College of Psychiatrists Centre for Quality Improvement

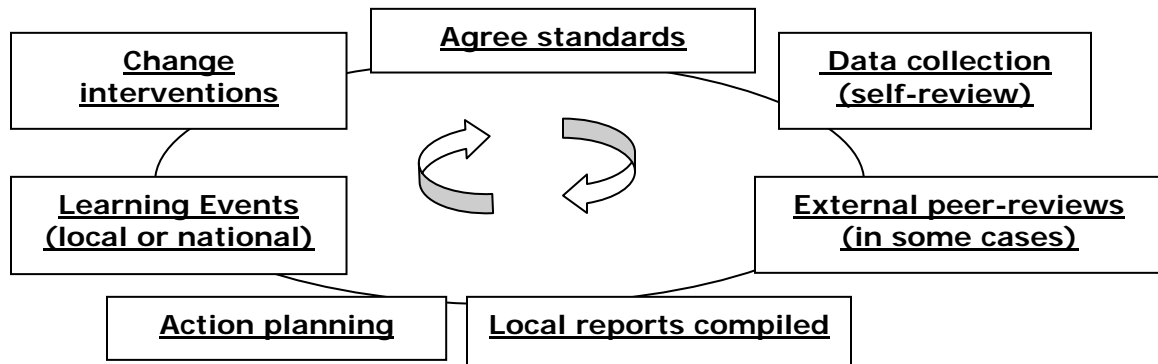
| Name of QI Audit | Duration |
|---|-----------------|
| Clinical Governance Support Service (CGSS) | 1999 – 2004 |
| The National Audit of Violence (NAV) | 1999 - present |
| The Quality Network for In-Patient Child and Adolescent Mental Health Services (QNIC) | 2000 - present |
| The 'Community of Communities' – a series of quality network for Therapeutic Communities | 2001 - present |
| The Electroconvulsive Therapy Accreditation Service (ECTAS) | 2002 - present |
| The 'Better Services for People who Self-Harm' QI project | 2005 - present |
| The Prescribing Observatory for Mental Health (POMH-UK) | 2005 – present |
| The Quality Improvement Programme for Multi-Agency Child and Adolescent Mental Health Services (QINMAC) | 2005 – present |
| Acute Psychiatric Wards Accreditation Service (APWAS) | 2005 – present |
| Medium Secure Unit Review Network (MSU) | 2006 - present |

Key features of the CQI programmes

- They do not manipulate treatment plans, or experiment with new clinical techniques.
- They do explore the extent to which services are complying with nationally agreed standards.
- They all share the same long-term aim: to increase compliance with nationally recognised standards, resulting in an improved quality of care for the patient group in question.
- All of the CQI projects follow a typical clinical audit process described in figure 1 below.
- Each project has developed its own manual of quality service standards based on the best available evidence, and collects data to help services identify aspects of service provision that require improvement.
- The CQI supports local teams in action planning and re-audits services periodically, to examine which improvements have been made.
- Services are encouraged to network with each other on a national or international basis to share ideas for best practice, helping all services to improve patient care.

This is facilitated by email discussion groups, newsletters, conferences and learning events delivered by the CQI.

Figure 1: The Clinical Audit Process



Conducting Audit to Accepted Ethical Standards

Although the risk attached to QI projects might be considered to be low, the CQI shares the view that "the dignity, rights, safety and well-being of participants must be the primary consideration".

Research Governance Framework for Health and Social Care, draft second edition, Autumn 2003
<http://www.dh.gov.uk/assetRoot/04/02/08/96/04020896.doc>

Below are some examples of the safeguards put in place by the CQI:

Protecting the safety, dignity and rights of participants

- Clinical audit at the CQI adheres to the Caldicott principles (1997), the Data Protection Act (1998), and the NHS confidentiality code of practice (2003).
- Potential participants are made fully aware that it is entirely their choice whether or not they take part in the any consultation or survey and are reassured that choosing not to participate will not affect the care that they receive in any way. This is stated clearly in the information provided and again re-iterated at the beginning of each and every survey.
- Participants are reminded of their right to withdraw from the audit at any stage, without providing an explanation.
- The information sheets provided by the CQI are written to the same level of detail as those produced by the Healthcare Research Team at the College Research and Training Unit (who do have to seek ethical approval for such materials), so members and participants can be assured of similarly high quality.
- The audits do not ask for any personal identifiers (e.g. name, date of birth, address).
- The anonymity of participants is protected throughout – views are collated along with those of many other participants, meaning that local teams are unable to identify the comments or ratings of individual respondents.
- Confidentiality and its limits are made clear to all participants
- Our service user advisors have opined that the level of distress associated with this work is no more than a satisfaction survey, and certainly no more than 'general clinical practice' – this is something that COREC have defined as an important factor.

Consulting with relevant experts

- All of the CQI audits have steering groups consisting of healthcare professionals and researchers and many also have extensive service user input. The steering groups play a key role in planning the work of the audit and ethical issues are discussed regularly. Where a question arises that appears to fall outside of the group's knowledge, specialist expert advice is carefully sought.
- Experienced members of the Healthcare Research Team, based at the Royal College of Psychiatrists Research and Training Unit are available to offer advice about methodology and ethics if required.
- Systematic mechanisms (evaluation forms, discussion groups, AGMs) are in place to ensure that network members can feed back their views on the methods being used and raise concerns at any stage of the process.
- All of the projects consult with service users (for example when writing the service standards) and some employ service users on the central project team to design service user questionnaires, and contribute to information sheets and guidance notes. This helps to ensure that data collection tools do not cause any distress to participants, and that information provided to service users is clear and jargon-free.

Conclusion

Although it is clear that the CQI audits do not fall under the remit of local or national research ethic committees, the CQI takes very seriously its responsibility towards conducting ethical audit. By putting into place the safeguards mentioned above, and continually reviewing its practice, the CQI is confident that its work would stand up to the scrutiny of any ethical committee.

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