South East Coast Ambulance Service NHS
NHS Foundation Trust

Clinical Audit Policy

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1 Introduction

1.1. South East Coast Ambulance Service NHS Foundation Trust ('the Trust') is committed to delivering effective, evidence based clinical care that contributes to improvements in patient outcomes.

1.2. Clinical audit enables the Trust to monitor and review its standards of clinical care and uses consistent and evidence-based methodology to promote a cycle of improvement in performance against national and local standards.

1.3. The outcomes from clinical audit should be used to inform local standards/procedures and consider new clinical interventions as they are introduced.

1.4. The outcomes from clinical audit must facilitate improvements in the quality of patient care and outcomes.

2 Aims and Objectives

2.1. To ensure that effective clinical audit plans, procedures and communications are in place:

2.1.1. To promote a consistent standard of high-quality care to all patients;

2.1.2. To develop a Trust wide understanding of how clinical audit contributes to continual quality improvement and improved patient outcomes;

2.1.3. To provide the opportunity for all Trust staff who are directly responsible for delivering patient care to participate in clinical audit;

2.1.4. To use clinical audit to facilitate changes in practice, and the development of high standards of clinical care.

3 Definitions

3.1 Clinical Audit

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, process and outcome of care are selected and systematically evaluated against explicit criteria. Where indicated changes are implemented at an individual, team or service level and further monitoring is used to confirm improvements in healthcare delivery.

3.2 Clinical Governance

A framework through which organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

3.3 **Clinical Audit Standard**

A threshold of the expected compliance for a criterion to be used in audit, usually expressed as a percentage of compliance.

3.4 **Clinical Audit Plan**

A document which indicates which clinical audit projects will be undertaken during the financial year and which gives a top-level visual indicator of progress against each stage of that project as the year progresses.

4 Policy Statement

4.1 The policy supports the clinical developments and direction for the Trust as laid out in the Trust Business Plans.

4.2 The policy reflects the Trust's continued commitment to be clinically focused, innovative and high performing.

5 Arrangements

5.1 Audit Processes

5.1.1 Data Collection

5.1.2 All data will be collected and stored in accordance with the supporting procedures of this policy and will comply with the Trust's information governance procedures as listed in section 11 of this document.

5.2 **Clinical audit types - topics considered for the annual clinical audit plans must:**

- Support the delivery of evidence-based best practice;
- Inform and influence evidence-based improvements in best practice;
- Contribute to the process of continuing learning and development;
- Meet the definition of clinical audit in 3.1.

5.3 **Clinical audit exclusions - topics which are not clinical audit:**

- Collection of data which is not related to measures of clinical care;
- Patient or staff surveys that do not relate to measures of clinical care;
- Routine on-going monitoring of outcome data, unless ***explicitly*** linked to the change process.

5.4 Clinical audit prioritisation:

Priority within the clinical audit plan must be given to:

- Statutory and mandatory requirements (related to clinical measures only);
- Commissioning requirements (related to clinical measures only);
- Trust requirements (Trust requirements could be to inform business development; as a result of trends analysis incidents or complaints; to inform innovations/Research & Development etc., but must be in relation to clinical measures only);
- Any additional requests for audits to be accommodated within a planned year will be reviewed by the Clinical Audit and Quality Sub Group (CAQSG) and a recommendation for decision submitted to the Quality and Clinical Governance Group (QCGG)
- Each topic must have an identified lead auditor.

5.5 Clinical audit reporting and communication

5.5.1 Reporting of progress against the Clinical Audit Plan including Clinical Outcome Indicators will be submitted to the CAQSG and onwards to the QCGG. The QCGG must approve all reports before onward submission to Trust Committee or Board level, or to any external stakeholder.

5.5.2 Clinical audit findings and learning outcomes will be communicated to Trust staff, patients, users, volunteer staff and any other invested stakeholder via mechanisms approved by the QCGG.

5.6 Engagement with Stakeholders

Appropriate stakeholders must be identified for each audit topic and all clinicians offered equal opportunity to participate in a clinical audit. Line managers will support clinicians to undertake clinical audit when operational capacity allows.

5.7 Learning and Development

Any learning and development needs identified during a clinical audit will be agreed with the Trust's Clinical Education (CE) department at the CAQSG, on which a senior CE representative is a member.

5.8 Evaluation

Evaluation and Clinical Audit should be seen exclusively of each other. This policy covers Clinical Audit (as defined in 3.1). Clinical Audit Procedures state the process for requesting audit topics for the Clinical Audit Plan. If during that process topics are deemed not to meet the definition of audit, the CAQSG will refer these requests to the QCGG who will determine the most appropriate course of action for that request.

5.9 Action Plans and Improvements

5.9.1 Not all clinical audits will require an action plan, i.e. where the outcome shows standards of performance or best practice are being met, or guidelines followed. This will be explicit in the audit summary.

5.9.2 Where an action plan is required it must be specific, measurable, achievable, relevant and time-bound and developed with the Quality Improvement Lead (QIL) and the lead manager identified by the CAQSG.

5.9.3 Plans must be developed in line with Healthcare Quality Improvement Partnership guidance, 'Best Practice in Clinical Audit', May 2020.

5.9.4 Plans must include an agreed date and method for re-evaluation or monitoring to measure improvements.

5.9.5 Plans must be signed off by the CAQSG who will monitor progress.

5.9.6 Plans may include the recommendation that a quality improvement project is commenced to address improvement opportunities identified through audit. Quality improvement projects will be delivered in-line with the Trust's approved methodology.

5.9.7 The Policy supports the clinical developments and direction for the Trust as laid out in the Trust's Business Plans.

5.9.8 The policy reflects the Trust's continued commitment to be clinically focused, innovative and high performing.

6 Responsibilities

6.1 The Chief Executive has overall responsibility for the strategic direction and operational management of the Trust.

6.2 The Chief Medical Officer has responsibility for identifying, developing and implementing a Clinical Audit Policy that supports the Chief Executive in their responsibility.

6.3 It is the responsibility of the Clinical Audit and Service Improvement Lead to draft, implement and update this policy in line with the Policy & Procedure for Development of Trust Policies & Procedures.

6.4 It is the responsibility of the Clinical Audit and Service Improvement Lead to ensure the Clinical Audit department works with colleagues across the Trust to embed this policy in daily practice.

6.5 It is the responsibility of all Trust staff to identify the need for change to policy as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly.

7 Competence

7.1 All staff involved in undertaking clinical audit must be able to demonstrate knowledge of the following areas:

- General audit principles and responsibilities
- Types of audit
- Planning an audit
- Data collection methods
- Improvement planning
- Audit reporting
- Information governance.

8 Monitoring

8.1 The Clinical Audit and Service Improvement Lead is responsible for ensuring that this document is reviewed and changed as necessary in response to any legislative, guidance or organisational changes, or every three years, whichever is sooner.

9 Audit and Review

9.1 The Clinical Audit and Service Improvement Lead will carry out a three-yearly review of this policy to ensure compliance against the objectives.

9.2 The CAQSG will review the policy in the event of any incidents or complaints regarding clinical audit.

9.3 Any issues with the Clinical Audit processes will be picked up through the Trust governance processes which if necessary, can ask for a review or revision of this policy.

9.4 All policies have their effectiveness audited by the responsible management group at regular intervals, and initially six months after a new policy is approved and disseminated.

9.5 Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development of Trust Policies and Procedures (also known as the Policy on Policies).

9.6 This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the is not working effectively.

9.7 All changes made to this policy will go through the governance route for development and approval as set out in the Policy on Policies.

10 Equality Impact Appraisal

11 References

11.1 HQIP, ‘Principles for Best Practice in Clinical Audit’; May 2020

12 Glossary

None