South East Coast Ambulance Service NHS
NHS Foundation Trust

Clinical Audit Procedure

Contents

1 Scope

1.1. The scope of this procedure is to define the clinical audit processes undertaken within South East Coast Ambulance Service NHS Foundation Trust (the Trust) that supports delivery of the aims and objectives of the Trust's Clinical Audit Policy.

1.2. This procedure details the activity required to ensure robust quality assured data underpins the implementation of the full audit cycle, which in turn contributes appropriately to evidence-based service improvement.

1.3. This procedure relates specifically only to how audit topics and plan schedules will be determined for each financial year within the context of an annual plan. It is not intended to provide an instructional framework for undertaking all clinical audit related activities within the Trust.

2 Responsibilities

2.1. The **Chief Medical Officer (CMO)** is the Executive lead responsible for clinical audit within the Trust.

2.2. The **Clinical Audit and Service Improvement Lead** is responsible for ensuring that this document and clinical audit practices meet any statutory, mandatory and/or external assessment requirements.

2.3. The **Clinical Audit and Service Improvement Lead** is also responsible for:

2.3.1. Ensuring all staff under their management are aware of the procedure and their responsibilities within it.

2.3.2. Identifying the need for change to procedure due to changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives.

3 Procedure

3.1. Commencing in quarter three and no later than the quarter four of each year, the final version of the annual Clinical Audit Plan (CAP) for the following year will be drafted. The mechanisms for identifying topics will be:

3.1.1. Review of the National Institute for Health and Care Excellence (NICE) guidance database, including established and in development guidelines and quality standards, to identify guidelines not yet included in Trust audits, or those where guidelines have changed;

3.1.2. A review of historical audits that require re-audit after implementation of recommendations;

3.1.3. Review of national clinical audits requirements including Ambulance Clinical Outcome Indicators;

3.1.4. Liaison with governance teams (e.g. Patient Experience, Patient Safety, Medicines Governance, Professional Practice, Operations Leadership, Midwifery and EOC Governance) to determine where clinical audit should be/can be providing assurance and the respective audit work to be undertaken;

3.1.5. In conjunction with the Head of Patient Safety Patient Experience and Public Involvement, the Clinical Audit and Service Improvement Lead will review all Serious Incidents (SIs) submitted to the Quality and Patient Safety Committee in the year to identify any potential clinical care concerns where assurance of broader Trust practice may be valuable and share these with the Clinical Audit & Service Improvement Manager (CASIM) for inclusion.

3.2. All themes identified through the stages above will be entered into a tracker by the Clinical Audit & Service Improvement Manager and scored against the Healthcare Quality Improvement Partnership (HQIP) quality impact analysis (see appendix A). Based on this analysis, topics will be stratified into three levels:

3.2.1. Level one audit – External 'must do'

3.2.2. Level two audit – Internal 'must do'

3.2.3. Level three audit – Best practice/local interest.

3.3. In liaison with the Clinical Audit and Service Improvement Lead, the Clinical Audit and Service Improvement Manager will develop each theme into an audit topic and clarify the purpose and primary aims of the audit. They will define the clinical guidance against which the audit criteria are to be based (e.g. Joint Royal Colleges Ambulance Liaison Committee (JRCALC), National Institute for Health and Clinical Excellence (NICE), Resuscitation Council (UK), Trust policy/procedure/guidelines/clinical management plans, Patient Group Directions etc.).

3.4. The Clinical Audit and Service Improvement Lead and CASIM will produce the Annual CAP document. This will be approved by the Clinical Audit and Quality Sub-Group (CAQSG) and the Quality and Clinical Governance Group (QCGG).

3.5. The Clinical Audit and Service Improvement Lead will review the draft topics and determine a schedule detailing how long each topic will take; priority will be dictated by statutory and/or mandatory audits where they relate to clinical measures, clinical risks, Directorate and Trust business plans and departmental resources; the CASIM will seek guidance from the Clinical Audit and Service Improvement Lead in this regard. Progress against this plan will be monitored at CAQSG and reported to QCGG.

3.6. The Clinical Audit and Service Improvement Lead will produce three quarterly Clinical Audit Reports and one Annual report detailing progress against the CAP, outcomes of clinical audit activity and progress of audit actions.

3.7. Any audit requests received after the CAP has been agreed must be submitted to the CAQSG for a decision as to whether to recommend it be added to the current year or if the request is to be archived and revisited for the following year's consideration. Any additional in-year inclusions supported by the CAQSG that put at risk delivery of any topic already contained within the annual CAP must be subject to agreement by the QCGG and reported to the Executive Team.

3.8. **Audit Planning:**

3.8.1. The lead auditor will be appointed from the clinical audit staff by the Clinical Audit and Service Improvement Lead.

3.8.2. The lead auditor, under supervision from the Clinical Audit and Service Improvement Lead, will arrange a discussion with the key stakeholders for that topic to establish the framework under which the audit will be conducted. This will include, but is not limited to:

- The sample size and/or audit period.
- Any demographic, geographic and/or operational requirements.
- The audit criteria which reflects the best practice of clinical standards and the expected standard of the Trust's performance.

3.9. **Data collection:**

3.9.1. The lead auditor will collect the data in accordance with the Trust's information governance procedures.

3.9.2. Any delays and/or interruptions to data collection must be communicated by the lead auditor at the earliest opportunity to the CASIM who will advise and guide on alternative methods of data collection. If an alternative method cannot be used the CASIM will report this to the Clinical Audit and Service Improvement Lead to agree remedial action or revision to the CAP.

3.10. **Analysis and reporting:**

3.10.1. The collected data will be analysed and compared to the agreed standards by the project lead.

3.10.2. Agreed scope of an audit will not be changed but in the event of unexpected findings being identified the methodology, analysis and reporting of an audit can be expanded to further inform existing findings.

3.10.3. The lead auditor must immediately escalate unexpected findings during an audit to the Clinical Audit and Service Improvement Lead.

3.10.4. If the Clinical Audit and Service Improvement Lead deems the finding to expose or present a risk to patients or staff, then Trust incident reporting procedures must be followed and the issue must immediately be escalated to the CMO via email. Where appropriate, an entry to the Trust risk register will be made by the appropriate risk owner.

3.10.5. The lead auditor will compile a clinical audit report using the current Clinical Audit Templates, which will adhere to Trust formatting standards, be the de-facto standard for clinical audits within the Trust and adhere to best practice.

3.10.6. The lead auditor will be responsible for collating and presenting findings and observations, however if they are not a registered clinician, they will not be responsible for making draft recommendations based on these.

3.10.7. The Clinical Audit and Service Improvement Lead will review the findings and add draft recommendations and, if appropriate, additional observations to the report.

3.11. **Action Plan:**

3.11.1. The Clinical Audit and Service Improvement Lead will work with key stakeholders to draft an action plan based on these recommendations and suggest how these can be implemented. Such improvements can be either individual, team based, geographically located or at the Trust level – depending on the results and the associated impact on clinical care.

3.11.2. On completion of a clinical audit report to draft recommendations and action plan level, the report will be disseminated by the lead auditor to the CAQSG, and all associated stakeholders involved to that point, for comment with the response time determined by the CAP schedule.

3.11.3. The Clinical Audit and Service Improvement Lead will review all feedback with the lead auditor and accommodate any necessary changes.

3.11.4. The Clinical Audit and Service Improvement Lead will send the agreed final draft report to the QGG.

3.12. **Implement change:**

3.12.1. A recommendations action log will be collated in a central spreadsheet and the Clinical Audit and Service Improvement Lead will maintain this document, obtain updates from lead managers and report back on progress or issues to the CAQSG.

3.12.2. The Clinical Audit and Service Improvement Lead will include this log as an appendix to the Clinical Audit Report submitted to the QCGG and escalate any issues that cannot be resolved at the CAQSG.

3.13. **Re-audit:**

3.13.1. Where a re-audit is recommended as part of an agreed action plan a timeframe will be agreed at that stage.

3.13.2. Re-audit will take place under the same conditions and methodology as the original audit; whenever possible.

4 Audit and Review

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

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

4.3. 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 procedure.

4.4. All procedures have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy is approved and disseminated.

4.5. 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).

4.6. 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 procedure is not working effectively.

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

5 Equality Analysis

5.1. The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion or Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

5.2. Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.

Appendix A: HQIP Quality Impact Analysis Standards

Criteria	No relevance (0)	Some relevance (1)	Almost met (2)	Fully met (3)	Score
High cost					(x2)
High volume					
High risk					(x2)
Evidence of a quality problem					(x2)
Wide variation in practice					
Good evidence available to inform audit standards					
Likely to improve healthcare outcomes as well as process improvements					
Likely to have economic and efficiency benefits					(x2)
Topic is a key professional or clinical interest					
Reliable sources of data readily available					
Reasonable time frame for completion					
Potential for change					(x2)
Scope for direct involvement of patients and carers					
Multidisciplinary project					
Interface project *					
TOTAL SCORE					

Appendix B: Equality Analysis Record

Equality Impact Assessment (EIA) template (refer to guidance)

What piece of work does this relate to: Clinical Audit Procedure – 3 year periodic review and update
Lead author: Sophie Clark **Role:** Clinical Audit and Service Improvement Lead

1. Is this a:

- Change to an existing strategy (long term plan of action), policy or procedure ☒
- **Change to a service or function (actions or activities)** ☐
- A new strategy or policy/procedure/business case/ ops bulletin etc. ☐
- A new service or function ☐
- Project which requires approval at Board or Working group ☐

2. Who will be impacted by this work? Tick all that apply.

Patients ☒ Carers ☐ Staff	Student/learners ☐ Trade unions ☐ Suppliers ☐	Volunteers ☐	External Partners (please specify below) ☐ Click or tap here to enter text. Other (including a particular geographical area, describe below) ☐ Click or tap here to enter text.

3. Summarise the work being assessed. Describe current status followed by any changes that stakeholders would experience.

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. The outcomes from clinical audit should be used to inform local standards/procedures and consider new clinical interventions as they are introduced. The outcomes from clinical audit must facilitate improvements in the quality of patient care and outcomes.

The EIA is in respect of the 3 year periodic review and updated version of the Clinical Audit Procedure. Changes has been made to update job titles, governance group titles and clarify definitions.

4. Checklist

All the Trust’s policies, programmes, strategies, services and major developments affect patients, carers, service users, employees and the wider community. These will have a greater or lesser relevance to equality, diversity and inclusion.

The following questions will help you to identify how relevant your proposals are.

When considering these questions think about age, carers, disability, gender reassignment, race, religion or belief, sex, sexual orientation, pregnancy and maternity and any other relevant characteristics (for example socio-economic status, social class, income, unemployment, residential location or family background and education or skills levels).

Make notes to assist with the completion of the EIA.

Questions	Yes	No
Is there potential for/ indication of or evidence that the proposed change will affect different population groups differently (including possibly discriminating against certain groups)?	☐	☒
Have there been or are there likely to be any public concerns (including media, academic, voluntary or sector specific interest) about the change?	☐	☒
Could the proposal affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☒
Could the proposal affect our workforce or employment practices?	☐	☒
Is there potential for or evidence that the proposed change will not promote equality of opportunity or promote good relations between different groups?	☐	☒
If yes to any of the above , please add information in the notes		

5. Equality Impact Assessment

5.1. Key stakeholders

A key principle for completing Equality impact assessment is that they should not be done in isolation. Consultation with affected groups and stakeholders needs to be built in from the start, to enrich the assessment and develop relevant mitigation. Detail here who you have involved with completing this EIA.

Name / Group	Organisation	Role on assessment team e.g., service user, manager of service, specialist (which area)
Patricia Bucher	SECAmb	Clinical Audit & Service Improvement Manager
Sophie Clark	SECAmb	Clinical Audit & Service Improvement Lead
Nicola Brooks	SECAmb	Associate Director of Quality and Compliance
CAQSG	SECAmb	Governing body for clinical audit

5.2. Who may be positively or negatively affected by this activity?

Protected characteristics (Equality Act 2010)

Age ☐
Disability ☐
Race ☐
Gender reassignment ☐
Marriage & civil partnership ☐
Pregnancy & maternity ☐

In addition, consider the following vulnerable groups:

Armed forces ☐
Carers ☐
Digital exclusion ☐
Domestic abuse ☐
Education (literacy) areas ☐
Homeless ☐

Socioeconomic disadvantage ☐
People with addiction or substance misuse problems ☐
People on probation ☐
Prison population ☐
Undocumented migrant, refugees, asylum seekers ☐
Sex workers ☐

Religion & beliefs (including no belief) ☐
Sex (male or female) ☐
Sexual orientation ☐

Looked after children ☐
Rural areas ☐
Urban areas ☐

Other (please specify below) ☐

5.3. **Assessment outcomes** – discussion undertaken between Click or tap to enter a date. and Click or tap to enter a date.

Protected equality characteristic	Describe here the considerations and concerns in relation to the programme/policy for the selected groups. These may be positive, negative or neutral if there is no impact.	If you have identified any negative impacts, describe here suggested mitigations to inform the actions needed to reduce inequalities.
Age	Neutral	
Disability	Neutral	
Race[1]	Neutral	

[1] An ethnic group or ethnicity is a named social category of people who identify with each other on the basis of shared attributes that distinguish them from other groups such as a common set of traditions, ancestry, language, history, society, culture, nation, religion, or social treatment within their residing area. A useful guide to terminology can be found here: https://www.lawsociety.org.uk/topics/ethnic-minority-lawyers/a-guide-to-race-and-ethnicity-terminology-and-language

Gender reassignment	Neutral	
Marriage & civil partnership	Neutral	
Pregnancy & maternity	Neutral	
Religion & beliefs	Neutral	
Sex	Neutral	
Sexual orientation	Neutral	

Vulnerable groups/existing inequity	Describe here the considerations and concerns in relation to the programme/policy for the selected groups. These may be positive, negative or neutral if there is no impact.	If you have identified any negative impacts, describe here suggested mitigations to inform the actions needed to reduce inequalities.
Armed forces	Neutral	
Carers	Neutral	

Vulnerable groups/existing inequity	Describe here the considerations and concerns in relation to the programme/policy for the selected groups. These may be positive, negative or neutral if there is no impact.	If you have identified any negative impacts, describe here suggested mitigations to inform the actions needed to reduce inequalities.
Digital exclusion[2]	Neutral	
Domestic abuse	Neutral	
Education (literacy)	Neutral	
Homeless	Neutral	
Looked after children	Neutral	
Rural/urban geographies	Neutral	

[2] **Digital Exclusion can be linked to the following key root causes:**

- Connectivity access to the internet – can include financial barriers as well as suitable broadband speeds/connectivity
- Digital Skills the ability to use digital tools such as email, online shopping, digital healthcare - also includes having confidence in online safety, and how to utilise particular services or apps
- Technology and Accessibility access to appropriate devices to suit their individual needs – includes access to devices suitable for use with a certain disability as well as financial and location barriers
- Not wanting to use digital platforms simply not wishing to utilise digital services – this could be due to distrust of providers, online security, privacy etc.

Vulnerable groups/existing inequity	Describe here the considerations and concerns in relation to the programme/policy for the selected groups. These may be positive, negative or neutral if there is no impact.	If you have identified any negative impacts, describe here suggested mitigations to inform the actions needed to reduce inequalities.
Socioeconomic disadvantage	Neutral	
People with addiction or substance misuse problems	Neutral	
People on probation	Neutral	
Prison population	Neutral	
Undocumented migrants, refugees, asylum seekers	Neutral	
Sex workers	Neutral	
Other	Neutral	

5.4 Impact on Human Rights

If a provision or feature of your policy or service potentially unlawfully interferes with a human right then it is negative . If something protects or promote a human right, then it is positive. Human rights and freedoms belong to everyone. They give the legal basis to basic values of fairness, respect, equality, dignity and autonomy. They provide a set of minimum legal standards for all public bodies, including the NHS. They protect an individual’s rights whilst considering the rights of other people and wider society.

Human Rights	Describe here the considerations and concerns in relation to the programme/policy for the selected groups. These may be positive, negative or neutral if there is no impact.	If you have identified any negative impacts, describe here suggested mitigations to inform the actions needed to reduce inequalities.
A2. Right to life (e.g. Pain relief, DNAR, competency, suicide prevention)	Neutral	
A3. Prohibition of torture, inhuman or degrading treatment (e.g., Service Users unable to consent)	Neutral	
A4. Prohibition of slavery and forced labour (e.g., Safeguarding vulnerable patients' policies)	Neutral	
A5. Right to liberty and security (e.g., Deprivation of liberty protocols, security policy)	Neutral	
A6&7. Rights to a fair trial; and no punishment without law (e.g., MHA Tribunals)	Neutral	
A8. Right to respect for private and family life, home and correspondence (e.g., Confidentiality, access to family etc)	Neutral	
A9. Freedom of thought, conscience and religion (e.g., Animal-derived medicines/sacred space)	Neutral	
A10. Freedom of expression (e.g., Patient information or whistle-blowing policies)	Neutral	
A11. Freedom of assembly and association (e.g., Trade union recognition)	Neutral	
A12. Right to marry and found a family (e.g., fertility, pregnancy)	Neutral	

Human Rights	Describe here the considerations and concerns in relation to the programme/policy for the selected groups. These may be positive, negative or neutral if there is no impact.	If you have identified any negative impacts, describe here suggested mitigations to inform the actions needed to reduce inequalities.
P1.A1. Protection of property (e.g., Service User property and belongings)	Neutral	
P1.A2. Right to education (e.g., accessible information)	Neutral	
P1.A3. Right to free elections (e.g., Foundation Trust governors)	Neutral	

6. Action plan and monitoring arrangements

Insert your action plan here (example layout provided). This should be based on mitigations recommended in 6.2. Involve your key stakeholders in monitoring progress against the actions above, and add more rows as required.

ACTIONS & DECISIONS TRACKER					
What is being assessed: Periodic review and update of existing Clinical Audit Procedure					
What management group will have oversight of these actions (this should be the group which has oversight of the change):					
Item	Initiation Date	Action/Item	Person Actioning	Target Completion Date	Update/Notes
1	Oct 23	Clinical Audit Procedure to be presented at JPF	Patricia Bucher	Nov 23	
2					
3					

4					

The above actions should be added to the action log for the named management group.

7. Inclusion Working Member for directorate

Based on your assessment, please indicate which course of action you are recommending to the author. You should explain your recommendation in the blank box below.

Outcome No.	Description	Tick
Outcome One	**No major change to the proposal required.** This EIA has not identified any potential for discrimination or negative impact, and all opportunities to promote equality have been undertaken. Proceed with the programme and review EIA mid-programme.	✓
Outcome Two	**Adjust the proposal** to remove barriers identified by the EIA or better advance equality. Are you satisfied that the proposed adjustments would remove the barriers you identified? Proceed with adjustments, amend programme and review EIA mid-programme.	
Outcome Three	**Continue the proposal** despite potential for negative impact or missed opportunities to advance equality identified. You will need to make sure the EIA clearly sets out the justifications for continuing with it. You need to consider whether there are: Sufficient plans to stop or minimise the negative impact. Consider if risks need adding to the risk register. Mitigating actions for any remaining negative impacts plans to monitor the actual impact. Proceed with programme. Monitor and evaluate. Discuss with responsible management group and Inclusion Team for advice where required.	
Outcome Four	**Stop and rethink** the service change/proposal when the EIA shows actual or potential unlawful discrimination. Review change/proposal with the responsible management group for this area of work and identify alternative way forward	

Please use the box on the right to explain the rationale for your recommendation:	This is the required 3 year period review and update of the existing Clinical Audit Procedure. The changes made to the procedure include: • Update to job titles • Updated governance group titles • Definitions clarified

8. Governance

Sign off	Inclusion Working Member for directorate	Date:

9. Version Control

Version Number	Purpose/Change	Author	Date

The above provides historical data about each update made to the EIA.

Please include the name of the author, date and notes about changes made – so that you are able to refer back to what changes have been made throughout this iterative process.
Please send an approved copy of this EA to inclusion@secamb.nhs.uk and polsandprocs@secamb.nhs.uk

Document Control

Manager Responsible

Name:	Sophie Clark
Job Title:	Clinical Audit and Service Improvement Lead
Directorate:	Medical

Committee/Working Group to approve	JPF

Draft/Evaluation/Approval (Insert stage of process)

Person/Committee	Comments	Version	Date
Chief Medical Officer Clinical Audit and Service Improvement Lead Clinical Audit and Service Improvement Manager JPF Quality Clinical Governance Group	Updated job titles Updated to reflect current working practices Updated reporting titles Updated governance group titles	6.0	13/09/23
Head of Clinical Audit, Quality Improvement Lead, Clinical Audit Supervisor	Updated job titles.	5.3	20/08/20
Head of Clinical Audit	Updated following consultation	5.2	01/11/19
Executive Medical Director & Associate Director of Patient Outcomes and Experience	Updated following feedback.	5.1	15/08/19
Head of Clinical Audit	Updated to reflect current working practices	5.0	15/07/19
CAQSG	Amendments to update existing procedure	4.01	01/07/2019
JPPF	12 month extension to existing procedure approved	4.00	31/07/2018
CQWG	Approved	4.00	03/02/2015
Clinical Audit Lead	Amendments to document following CQWG	3.03	03/02/2015
Clinical Audit Lead	Formatting changes to meet Trust template	3.02	19/01/2015
Clinical Quality Working Group	Correction of job title in 3.1. Addition of process at 3.1.4	3.01	09/12/2014
Clinical Quality Working Group	To agree changes to procedure	2.01	10/04/2014
Clinical Governance Working Group	To agree changes to procedure	1.01	10/04/2012
Clinical Governance Working Group	Formatting changes required to meet new Trust template	1.00	25/10/2011

Circulation

Records Management Database	Date:
Internal Stakeholders	
External Stakeholders	

Review Due

Manager	Quality Improvement Lead	
Period	Every three years or sooner if new legislation, codes of practice or national standards are introduced	

Record Information

Security Access/Sensitivity	Official (Public Domain)
Publication Scheme	No
Where Held	Records Management database
Disposal Method and date:	

Supports Standard(s)/KLOE

	Care Quality Commission (CQC)	**IG Toolkit**	**Other**
Criteria/KLOE:	Name core service area and CREWS elements		