NHS
South East Coast Ambulance Service
NHS Foundation Trust

Clinical Audit Policy

Contents

Document Control

Formal approval:

Final approval by:	Joint Partnership Forum	
Version No. V7	Final	25/07/2025
Responsible Management Group approval by:	Clinical Audit and Quality Sub-Group	
Version No. V7	Final	25/07/2025

Review/comments:

Person/Committee	Comments	Version	Date
Clinical Audit and Service Improvement Lead. Clinical Audit & Service Improvement Manager	Updated following periodic review to include: • Updated job titles • Updated governance group titles • Definitions clarified	5	12/09/23
Head of Clinical Audit, Quality Improvement Lead, Clinical Audit Supervisor	Updated following periodic review to include: • Updated job titles • Updated governance group titles • Updated references for best practice • Definitions clarified.	4.1	20/08/20
Quality and Safety Committee	To recommend for approval the following changes • Change of Clinical Audit & Guidelines Sub Group (CAQSG) to Clinical Audit Quality Sub Group (CAQSG) • Change Clinical Quality Working Group (CQWG) to Quality & Safety Committee (QSC) • Change Clinical Quality Manager (Clinical Audit &	4 Throughout Throughout Throughout	14.06.17

	Safeguarding) to Head of Clinical Audit (HCA) • Risk Management & Clinical Governance Committee (RMCGC) to Quality and Safety Group (QSG) • Learning & Development (L&D) to Clinical Education (CE)	Throughout 5.7.1	
RMCGC	Approved	3.0	08/05/2014
Clinical Quality Working Group	To recommend for approval of changes to: • Change of CGWG to CQWG • Change of job title of CAM to CAL • Change to 5.9.5 – plans signed off by CQWG and not Medical Director • Date removed from references to Clinical Strategy • Associated documents updated	2.01	10/04/2014
Clinical Governance Working Group	To recommend for approval of small changes	1.01	10.04.2012

Circulation

Records Management Database	Date:	25/07/2025
Internal Stakeholders		
External Stakeholders		

Review Due by responsible Management Group:

Manager	Head of Clinical Audit	
Period	Every three years or sooner if new legislation, codes of practice or national standards are introduced Date:	25/07/2028

Record Information

Security Access/Sensitivity	Public Domain
Publication Scheme	Yes
Where held	Corporate Records Register
Disposal Method and date:	In line with national guidelines

Supports Standard(s)/KLOE

	NHS Litigation Authority (NHSLA)	Care Quality Commission (CQC)	Auditors Local Evaluation (ALE)	IG Toolkit	Other
Criteria/KLOE:	**N/A**	**Reg 17**			

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 **Health Informatics Annual 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 Health Informatics Annual 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 Health Informatics Annual 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 Nursing 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 Head of Health Informatics and Records 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 Head of Health Informatics and Records 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 audits
- Planning an audit
- Data collection methods
- Improvement planning
- Audit reporting
- Information governance.

8 Monitoring

8.1 The Head of Health Informatics and Records 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 Head of Health Informatics and Records 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

10.1 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 and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

10.2 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.