NHS
South East Coast Ambulance Service
NHS Foundation Trust

Clinical Audit Procedure

Contents

Document Control

Formal approval:

Final approval by:	Joint Partnership Forum	
Version No. V8	Final	25/07/2025
Responsible Management Group approval by:	Clinical Audit and Quality Sub-Group	
Version No. V8	Final	25/07/2025

Review/comments:

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	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	15/07/19
CAQSG	Amendments to update existing procedure	4.01	01/07/2019
JPPF	12-month extension to existing procedure approved	4	31/07/2018
CQWG	Approved	4	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	25/07/2025
Internal Stakeholders	
External Stakeholders	

Review Due by responsible Management Group:

Manager	Quality Improvement Lead	
Period	Every three years or sooner if new legislation, codes of practice or national standards are introduced	25/07/2028

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		

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 Nursing Officer (CNO) is the Executive lead responsible for clinical audit within the Trust.

2.2. The Head of Health Informatics and Records is responsible for ensuring that this document and clinical audit practices meet any statutory, mandatory and/or external assessment requirements.

2.3. The **Head of Health Informatics and Records 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 Health Informatics Annual Plan 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 Patient Safety, Patient Experience and Public Involvement teams, the Head of Health Informatics and Records 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 Health Informatics Managers for inclusion.

3.2. All themes identified through the stages above will be entered into a tracker by the Health Informatics Managers 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. National– External ‘must do’

3.2.2. Trust/Local – Internal ‘must do’

3.2.3. Ad hoc Requests– Best practice/local interest.

3.3. In liaison with the Head of Health Informatics and Records, the Health Informatics Managers 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 Health Informatics Managers and Head of Health Informatics and Records will produce the Health Informatics Annual Plan 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 Head of Health Informatics and Records 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 Health Informatics Managers will seek guidance from the Head of Health Informatics and Records in this regard. Progress against this plan will be monitored at CAQSG and reported to QCGG.

3.6. The Head of Health Informatics and Records will produce three quarterly Departmental Progress/Update Reports and one Annual Report detailing progress against the Health Informatics Annual Plan, outcomes of clinical audit activity and progress of audit actions and learning.

3.7. Any audit requests received after the Health Informatics Annual Plan 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 Health Informatics Plan 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 Head of Health Informatics and Records

3.8.2. The lead auditor, under supervision from the Head of Health Informatics and Records, 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 reflect 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 Health Informatics Managers who will advise and guide on alternative methods of data collection. If an alternative method cannot be used the Health Informatics Managers will report this to the Head of Health Informatics and Records to agree remedial action or revision to the Health Informatics Annual Plan.

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 Head of Health Informatics and Records.

3.10.4. If the Head of Health Informatics and Records deems the finding to expose or present a risk to patients or staff, then Trust incident reporting procedures must be followed. 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 Head of Health Informatics and Records will review the findings and add draft recommendations and, if appropriate, additional observations to the report.

3.11. **Action Plan:**

3.11.1. The Head of Health Informatics and Records 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 Health Informatics Annual Plan schedule.

3.11.3. The Head of Health Informatics and Records will review all feedback with the lead auditor and accommodate any necessary changes.

3.11.4. The Head of Health Informatics and Records 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 Head of Health Informatics and Records will maintain this document, obtain updates from lead managers and report back on progress or issues to the CAQSG.

3.12.2. The Head of Health Informatics and Records 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 Head of Health Informatics and Records 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					