East of England Ambulance Service NHS Trust

Clinical Audit Policy

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DOCUMENT CHANGE HISTORY		
Initiated by	**Date**	**Author (s)**
Trust Requirement	June 2008	Clinical Specialist (Quality)
Version	**Date**	**Comments (i.e., viewed, or reviewed, amended approved by person or committee)**
V1.0	08/09/2008	Approved by Integrated Governance Committee
2.0	August 2009	Minor adjustments made in response to NHSLA feedback

Version	Date	Comments (i.e., viewed, or reviewed, amended approved by person or committee)
3.0	July 2010	Updates including post new directorate and governance structure. Re-approval
4.0	15 August 2011	Approved by Executive Management Team
5.0	15 October 2015	Approved by Executive Leadership Board
6.0	30 November 2017	Formal ELB ratification
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9.0	20 November 2020	Approved by Compliance and Risk Group
9.1	02 November 2023	Reviewed by Clinical Audit Manager and Head of Compliance
9.1	06 November 2023	Approved by Clinical Best Practice Group (Chair's action)
10.0	27 November 2023	Approved by Compliance and Risk Group

Document Reference	Health and Social Care Act 2012 (Regulated Activities) Regulations 2014 Care Quality Commission (Registration) Regulations (Part 4) Key lines of enquiry, prompts and ratings characteristics for healthcare services (CQC: June 2017) Directorate: Clinical Quality Directorate
Recommended at **Date**	Clinical Best Practice Group (Chair's action) 6 November 2023
Approved at **Date**	Compliance and Risk Group 27 November 2023
Valid Until Date	31 December 2026 (unless prompted earlier through Trust requirement or change in guidance)
Equality Analysis	Completed 02 November 2023
Linked procedural documents	None
Dissemination requirements	All Trust staff and members of the public via publication on the Trust website
Part of Trust's publication scheme	Yes

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.

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1. Introduction

Clinical audit is a crucial part of the Trust's strategy to improve health care to service users. The evaluation of clinical performance against standards or through comparative analysis, with the aim of informing the management of services, is an essential component of modern healthcare provision. It forms part of the Trust's clinical governance arrangements helping to ensure safe and effective clinical practices.

There is a continuous drive towards evidence-based decision making and practice and a growing recognition amongst providers to provide the highest possible quality of care based on knowledge gained from rigorous and well conducted research. Clinical audit is a key mechanism in this process through monitoring compliance with standards, guidelines and patient outcomes.

In addition, the regulatory framework of the Care Quality Commission (CQC) requires registered healthcare providers to monitor the quality of their services. The CQC fundamental standards describe the care patients should expect, and provides prompts for providers to consider when aiming to meet requirements for governance and audit.

Providers must use the findings from clinical audits and other quality improvement initiatives, including those undertaken at a national level to ensure that action is taken to protect people who use services. They must also ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development).

When carried out in accordance with best practice, clinical audit:

- Improves the quality of care and patient outcomes
- Provides assurance of compliance with clinical standards
- Identifies and minimises risk, waste and inefficiencies

Participation in both national and local clinical audit is a statutory and contractual requirement for healthcare providers. The NHS standard contract forms the agreement between commissioners and providers of NHS-funded services, who must:

- Participate in national clinical audits within the National Clinical Audit and Patient Outcomes Programme (NCAPOP) relevant to their services
- Make national clinical audit data available to support publication of consultant-level activity and outcome statistics
- Implement and/or respond to all relevant recommendations of any appropriate clinical audit
- Implement an ongoing, proportionate programme of clinical audit of their services in accordance with good practice
- Provide to the co-ordinating commissioner, on request, the findings of any audits carried out, in particular locally-agreed requirements such as Ambulance Clinical Quality Indicators (ACQIs)

Under the Health Act 2009 NHS Trusts are required to produce an annual Quality Account which must include information on participation in national and local clinical audits, and the actions that have been taken as a consequence to improve the services provided.

It is intended that Clinical Audit will aid clinicians and managers to measure the extent to which day to day clinical practices meet agreed standards and to make improvements in performance if required, in order to improve patient outcomes and enhance their quality of life.

2. Purpose

The purpose of this policy is to set out the rationale for clinical audit and provide a framework for such activity, including standards,

guidance and procedures, as well as details of the support available from the Clinical Audit Team:

- For registering and approving clinical audit project proposals
- For developing and designing clinical audit projects

This policy aims to support a culture of best practice in the management and delivery of clinical audit, and to clarify the roles and responsibilities of all staff involved.

This document sets out the key principles for conducting a clinical audit within the Trust. The Trust is committed to improving health care provision through improvement initiatives and will actively encourage all clinical staff and those in training to be involved in clinical audit.

This policy should be referred to when organising clinical audit activity and when organising systems of clinical practice. The policy sets out Trust's decisions on clinical audit and guides best practice.

The Policy applies Trust wide, covering all services and departments including the auditing of patient records completed by organisations acting on behalf of EEAST, such as, Independent Ambulance Providers and Air Ambulance Charities.

This policy is intended to:

- Make a clear statement of the Trust's intentions to embed clinical audit throughout all its clinical activities
- Set rules for those involved in clinical audit activity to manage activity in a consistent manner and in accordance with best practice where ever possible

2.1 Key Points of the Policy:

- Clinical audit will be an integral part of clinical service delivery and clinical governance
- An annual programme of clinical audit will be agreed and delivered, developed and monitored by the Clinical Best Practice Group

- Department / function heads are responsible for the delivery of audit and monitoring activity within their department / function
- The Clinical Audit Programme will be facilitated and monitored by the Trust's Clinical Audit Department
- All clinical audits should be registered with the Clinical Audit Department

3. Duties

3.1 Chief Allied Health Professional (AHP) and Director of Quality and Improvement

The Chief AHP and Director of Quality and Improvement is accountable for clinical audit and the setting and monitoring of clinical standards.

3.2 Quality Governance Committee

The Committee is directly accountable to the Board and is responsible for ensuring the delivery of high quality care that is as safe and effective as possible. In particular;

- the monitoring and evaluating clinical quality and performance
- reviewing assurance on the outcomes of Clinical Audit
- final approval and monitoring progress of the annual clinical audit plan

The Committee will receive reports relating to all aspects of the plan and is responsible for raising concerns or highlighting issues in order to provide assurance to the Board.

3.3 Compliance and Risk Group

The Compliance and Risk Group receives exception reports from the Clinical Best Practice Group in line with the Trust's Governance Framework

3.4 Clinical Best Practice Group

The Clinical Best Practice Groups is responsible for;

- designing the clinical audit annual plan ensuring it takes into account nationally mandated audit requirements, themes identified from patient feedback and incidents and that it is aligned with the clinical direction of the Trust.
- setting of actions and monitoring completion against deadlines
- escalating concerns to the Compliance and Risk Group

3.5 Head of Compliance

The Head of Compliance will:

- Ensure that systems and processes are in place to facilitate the Clinical Audit plan
- Ensure recommendations and associated actions are identified and
- logged on the Trust's Clinical Audit action tracker.
- Ensure that the department meets its reporting requirements, both internally and to external organisations.

3.6 Clinical Audit Manager

The Clinical Audit Manager will:

- Review the Trust's Clinical Audit Policy
- Oversee delivery of the Trust's Clinical Audit Plan including the submission of data in relation to national reporting requirements
- Ensure the integrity and quality of data used within all audits
- Provide reports to the Head of Compliance and relevant committees/groups as defined above
- Ensure all related evidence is linked to the relevant Key Lines of Enquiry within the Trust's CQC evidence portfolio and contribute to the defined status updates.
- Provide support and training to clinical audit staff and operational members of staff where required.

3.7 Trust Leads, including clinical leads

Will:

- Understand their responsibilities within the Clinical Audit plan including undertaking audits of work they manage.
- Ensure that any actions assigned to themselves are completed in line with the agreed deadlines and that relevant evidence is provided and uploaded to provide assurance of completion, providing exception reports where there is slippage or non-completion.
- Ensure that audits are carried out in a robust manner and of an appropriate quality
- Ensure that appropriate changes are made as a result of feedback from audits and monitoring.

3.8 Operational Managers will:

- Meet objectives in relation to monitoring and auditing.
- Encourage and support local and regional clinical audit.
- Disseminate and review clinical audit reports and figures.
- Ensure that action plans are implemented at service level.
- Support staff at a local level to participate in clinical audit.

3.9 All staff

All staff employed by the Trust have a responsibility for the continual improvement of the quality of the service they provide. Clinical staff are individually accountable for ensuring they use audit data to inform and refine their own practice in accordance with their professional codes of conduct and the standards set out within this policy.

4.0 Definitions

4.1 "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" (NICE 2002).

4.2 "Clinical Audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes. By following the cycle, any clinician or team should be able to see where their practice can be improved against given benchmarks, to take action, and then to re- measure and make further improvements. Whether conducted by an individual on their own clinical work, for a whole clinical team or unit, or nationally by comparing providers in different organisations against each other, it is the same process. Its purpose is to drive up standards of quality and to achieve better outcomes." (Burgess R. 2011)

More simply put, clinical audit is a systematic process, used to evaluate and improve the quality of patient care by comparing actual practice against agreed indicators of good practice and to take action to make improvements when compliance is not met.

The clinical audit plan will include audits as defined within the national Ambulance Clinical Quality Indicators (ACQIs) as well as those identified through internal processes including but not restricted to concerns raised through incident reporting and patient feedback etc.

5.0 Development

5.1 Prioritisation of Work

The need for a policy to outline the Trust's requirements and processes in relation to clinical audit is indicated by organisations such as the Healthcare Quality Improvement Partnership (HQIP) and the National Institute of Clinical Excellence NICE to ensure that robust mechanisms are in place to measure and improve the quality of care delivered in line with the Health and Social Care Act Regulations.

5.2 Identification of Stakeholders

For the purposes of this Policy, stakeholders are all people who access or use the service or those who act on their behalf

5.3 Responsibility for Document's Development

The Clinical Audit Manager is responsible for the review and update of this policy every three years unless prompted earlier by changes within the Trust's governance framework or as identified by any internal audit reviews.

The policy will be approved in line with internal processes.

6.0 Conduct of Clinical Audit

6.1 Agreeing an annual plan

The content of the annual plan will be determined by a number of sources including;

- Nationally mandated audits
- Areas of concern highlighted by clinical incidents and patient feedback
- Changes to practice eg drugs, skills, clinical guidelines
- Drivers contained within the Trust's Clinical Strategy
- NICE recommendations

Audit topics will be categorised using the prioritisation tool (Appendix C) to ensure that topics of high importance such as nationally mandated audits are completed ahead of any locally defined topics.

The plan will be set and agreed by the Clinical Best Practice Group prior to submission to the Quality Governance Committee for final approval.

6.2 Use of databases

- All audit topics will be logged on the Trust's audit tracker which will be regularly updated and used to report to the

Clinical Best Practice Group in regards to outcomes and recommendations/actions completion.

- Data extracted from records for audit purposes will be managed and processed in line with the data protection legislation.
- Outcome reports will be held on the Trust's cloud server.

6.3 Use of standards in clinical audit

The majority of clinical audit activity will be measured against the Joint Royal College Ambulance Liaison Committee (JRCALC) guidelines, however in some instances, other sources such as NICE guidance will be used.

6.4 Reporting

Reports for each topic will be produced in line with the Corporate template and contain the following headings;

- Title page - To include the Trust name, project title which should include the audit topic, name of author, period of data collection and month of publication.

- Executive Summary - A precise of the report containing paragraphs of introduction, methodology, results and conclusion.

- Contents - Listing the following pages and headings

-Introduction - To include the rationale for the project

- Methodology - To include the clinical audit indicators, the sample and selection criteria, process method and outcome of any pilot of the methodology

- Results - Clear outcome of measuring the clinical audit indicators

- Analysis - Detailed review of the results with other information to particularly determine root cause of any unsatisfactory compliance

- Conclusion - Outcome of project

- Acknowledgements and Glossary - List of acknowledgements. Glossary if required
- References - List all references made using Harvard style
- Appendix - Supporting information as required
- Action Plan / Recommendations - If results are not sufficiently compliant an action plan to develop improvements should be written up and presented as a separate document

6.5 Dissemination

All audit outcome reports will be disseminated to operational management teams including the Director of Clinical Operations, managers within the clinical directorate and clinical commissioners.

In addition, a summary will be included within the annual Quality Account.

6.6 Action plans for improvement

The main purpose of clinical audit is to deliver improvements in clinical practice. Where the results of a clinical audit indicate sub-optimal practice, an action plan must be developed and implemented and its effects monitored. Following the completion of an audit topic, the results will be shared with the Clinical Best Practice Group who will be responsible for approving any associated recommendations.

6.7 Re-audit

To enable a robust audit framework within the organisation, re-audit of topics to understand as to whether implemented actions have been effective in raising the standard of care is essential. It is vitally important that re- audits are included within the setting of any annual plan.

6.8 Clinical audit annual report

A report will be produced annually on all audit activity, outcomes, identified areas of good practice, areas for improvement and further actions required.

A summary will also be included within the annual Quality Account

7.0 Ethics and consent

By definition, clinical audit projects do not require formal approval from a research ethics committee. However one of the principles underpinning clinical audit is that the process should do good and should not do harm therefore any ethical concerns that arise during the design and planning will be raised with the Trust's Research team for advice.

8.0 Monitoring

Compliance to this policy will be monitored in a number of ways:

- By day to day management activity
- By informal and formal internal auditing carried out by the Clinical Audit Department.
- By formal auditing by appointed external auditors, on a time scale agreed

Informal checking of compliance to the policy and to the quality of work should take place continually by managers and staff.

The Clinical Audit Manager will check a number of centrally controlled projects to ensure compliance against this Policy and that each of the projects listed on the Trust's Clinical Audit Programme has a written process, that the process is relevant, that standards used are relevant and that the project has been completed.

Issues arising would normally be dealt with by the Clinical Audit Manager or Head of Compliance, however significant issues which

cannot be resolved will be escalated to the Deputy Director of Clinical Quality.

Full details of monitoring can be found in Appendix B.

Appendices

A Audit Prioritisation Tool

B Monitoring Table

C Equality Analysis

APPENDIX A Clinical Audit Prioritisation Tool

The audit programme prioritisation tool has been developed using the prioritisation criteria set out below. It will ensure that audit topics will be prioritised in order of importance to EEAST. Once each audit topic has been scored, the audits will be ranked in terms of priority and these will form the work programme for the coming year.

Score each audit project against each criteria by the amount indicated – Score 0 if the criterion is not applicable.

Audit Title:		
Scoring Template		
Criteria	**Definition of Criteria**	**Scoring**
Clinical Risk	Risk assessment against EEAST Risk Matrix divided by 2.5 to give a score out of 10	Risk Assessment Score **/ 10**
National / regulatory audit	Is this a national /regulatory requirement	X5
Quality issue	Is there evidence of a serious quality problem eg complaints, clinician concern, untoward critical incidents and complication rates?	x5

Criteria	Definition of Criteria	Scoring
NICE guidance	Does the topic relate to a recently introduced treatment (Technological or Interventional) guideline?	x2
NICE Quality Standard	Is the topic related to a NICE Quality Standard?	x2
Patient led	Has the audit been prompted by a patient / carer?	x2
Staff led	Has the audit been prompted by a member of staff?	x1
Collaborative audit	Is this a collaborative audit?	x1
Volume	Is this an audit of high volume?	x1
Re-audit	Is this a re-audit?	x1
	TOTAL =	/30

Appendix B Monitoring table

What	Who	How	Frequency	Evidence	Reporting Arrangements	Acting on Recommendations	Change in practice & lessons to be shared
Process for setting priorities for clinical audit plan	Members of the Clinical Best Practice Group	Review of mandatory topics, concerns raised by incidents and patient feedback, NICE guidance, Trust's Cilnical Strategy-assessment through compliance software	Annually	Approved & Published plan	Compliance and Risk Group (CRG) Quality Governance Committee for assurance. The Board for information.	CRG will act on recommendations made by the Chair of the CBPG QGC will act on recommendations either from the Chair of CRG or direct reporting from the Compliance and Standards Lead	Improvements in the quality of care delivered Areas where improvements are required (identified actions)

What	Who	How	Frequency	Evidence	Reporting Arrangements	Acting on Recommendations	Change in practice & lessons to be shared
Process for ensuring that audit tools reflect evidence based practice	Clinical Audit Manager	1. Review of project methodology. 2.Review of available clinical audit templates	1. Spot checks throughout each year 2. Annually	Audit tools	As above	As above	None identified to date
Process for making improvements	Chair – CBPG	Review by CBPG	Bi-monthly	Audit tracker Minutes of meetings	As above	As above	Quality of care delivered
Process for monitoring action plans	Chair-CBPG	Review by CBPG	Bi-Monthly	Audit tracker Minutes of meetings	As above	As above	

Appendix C Equality Impact Assessment

EIA Cover Sheet	
Name of process/policy	Clinical Audit Policy
Is the process new or existing? If existing, state policy reference number	Existing POL020
Person responsible for process/policy	Clinical Audit Manager
Directorate and department/section	Clinical Quality Compliance and Standards
Name of assessment lead or EIA assessment team members	Head of Compliance
Has consultation taken place? Was consultation internal or external? (please state below):	No

The assessment is being made on:	

Guidelines	
Written policy involving staff and patients	X
Strategy	
Changes in practice	
Department changes	
Project plan	
Action plan	
Other (please state) Training programme.	

Equality Analysis					
What is the aim of the policy/procedure/practice/event? This document sets out the key principles for conducting clinical audit within the Trust					
Who does the policy/ procedure/ practice/ event/ impact on?					
Race	x	**Religion/belief**	x	**Marriage/Civil Partnership**	x
Gender	x	**Disability**	x	**Sexual orientation**	x
Age	x	**Gender re-assignment**	x	**Pregnancy/maternity**	x
Who is responsible for monitoring the policy/procedure/practice/event? Clinical Audit Manager					
What information is currently available on the impact of this policy / procedure / practice / event? The Policy meets all requirements /guidance released by the Department of Health in relation to data protection as well as legislative requirements / standards set by, amongst others, the Care Quality Commission					
Do you need more guidance before you can make an assessment about this policy/procedure/ practice/event? No					
Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics? Some equality, diversity and inclusion evidence is collected as part of the clinical audit process to determine demographics only. However clinical information specifically regarding pregnancy/maternity would be used as part of a specific audit eg Administration of medication following childbirth.					

Please provide evidence : Clinical Audit collects information relating to gender and age for demographic purposes. All conditions including disabilities may be included within a specific audit, however the information will not usually be used to report against specific backgrounds etc.

Race	x	**Religion/belief**	x	**Marriage/Civil Partnership**	x
Gender	x	**Disability**	x	**Sexual orientation**	x
Age	x	**Gender re-assignment**	x	**Pregnancy/maternity**	x

Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics?

No

Race	**Religion/belief**	**Marriage/Civil Partnership**
Gender	**Disability**	**Sexual orientation**
Age	**Gender re-assignment**	**Pregnancy/maternity**

Please provide evidence:

Not applicable

Action Plan/Plans - SMART

Not applicable

Evaluation Monitoring Plan/how will this be monitored?

Not applicable