NHS
Yorkshire
Ambulance Service
NHS Trust

Clinical Audit Policy

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Document Control Information

Version	Date	Author	Status (A/D)	Description of Change
2.1	Feb 2016	R. Neish	D	Rewrite to reflect changes of process and HQUIP recommendations CG to CGG and CGDG to CQDF
3.0	Sept 2016		A	TMG approval
3.1	June 2018	Risk team	A	New visual identity
3.2	May 2019	J Crossley/ J Wooller	D	Rewrite view to reflect CIA team and the introduction of a clinical audit guidance document
3.3	May 2019	J Crossley	D	Removal of flow chart and added Rand R charts
3.4	June 2019	J Crossley/J Wooller	D	Amended following May CGG comments/feedback
3.5	June 2019	J Crossley	D	EIA completed feedback Sept 2019 updated format to TMG
3.5.1	Dec 2019	J Crossley	A	Approved by TMG
3.6	Sept 2022	H Hickey/F Bell	D	Embedded PDFs written as appendices. References updated, role titles updated, clarification of roles. Updated reference to national and local audit processes.
3.7	Oct 2022	F Bell	D	Approved by Clinical Governance Group 14/10/2022.
4.0	Dec 2022	Risk Team	A	Approved at TMG
A = Approved D = Draft				
Document Author = F Bell, Head of Research and Development				
Associated Documentation: Quality Improvement Strategy, Information governance policy: Clinical Audit Procedure, Data Quality Policy, Records Management Policy, Management of External Recommendations Policy and Clinical Audit Programme (annual).				

Staff Summary

As a health care organisation, YAS has a duty to support clinical audit and to act on the findings as part of its quality assurance and governance processes. The purpose of this policy is to provide staff with the knowledge of the requirements, processes, and responsibilities in the conduct of clinical audit.
The purpose of this policy is to provide staff with the knowledge of the requirements, processes, and responsibilities in the conduct of clinical audit.
Registered clinicians are encouraged to undertake clinical audit as part of their registration requirements. This policy describes the duties and responsibilities of staff conducting clinical audit.
This policy describes the process of conducting clinical audit, including review and publication.
This policy describes how compliance with the policy will be monitored

1.0 Introduction

1.1 Clinical audit is a way to find out if healthcare is being provided safely and in line with standards; it highlights where services are performing well and draws attention to areas where improvements could be made. Clinical audit is a mandated activity for all

health care organisations and clinicians and must be carried out in accordance with best practice. This policy outlines how the trust will support, undertake, monitor, and communicate clinical audit.

1.2 The trust is committed to the continuous improvement of the quality of services offered to patients, carers, and families. Through its successful implementation clinical audit assists in the delivery of the trust's Clinical Strategy (2020-24) Quality Improvement (QI) Strategy, a strategy which outlines the trust's intended direction of travel and steps to be taken to ensure development of an approach to QI that is integrated and consistently utilised by staff and volunteers to improve the experience and outcomes for the patients served and to impact positively on their lives.

2.0 Purpose/Scope

2.1 Clinical audit is a key part of good governance and management of an organisation. The NHS Standard Contract requires that providers consider and respond to the recommendations arising from any audit, serious incident report or patient safety incident report and must implement and/or respond to all relevant recommendations. This policy sets out the trust's legal responsibility in relation to undertaking quality clinical audit, how it reports the findings and responds to learning and recommendations from the results. It outlines standards applied when following the audit cycle and through the clinical audit procedure document, guides staff in participating and conducting clinical audit activities and applies to anyone engaged in clinical audit.

2.2 Both national audits (including Ambulance Clinical Outcomes as part of the NHS England Ambulance Quality Indicators) and local clinical quality audits are within the scope of this policy.

2.3 YAS undertakes and reports clinical audit in line with the recommendations and guidance provided by HQIP https://www.hqip.org.uk/resources/.

2.3.1 YAS adopts the HQIP definition of clinical audit: '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.' [2]

3.0 Process

3.1 A programme of clinical audit will be defined annually and will take into account national audit programmes, past audit activity, themes and trends from investigations and feedback.

3.1.1 Implementation of changes in practice may also influence the clinical audit programme, as per the YAS Management of External Recommendations Policy.

3.1.2 A programme will be developed by the Clinical Informatics and Audit (CIA) team, prioritised, and refined by the membership of the Clinical Quality Development Forum (CQDF). Clinical Governance Group will approve the final audit programme.

3.1.3 Lead clinicians for each local clinical audit will be identified. The lead clinician will be responsible for the preparation of audit standards and criteria in collaboration with the CIA based on an understanding of the quality and availability of data.

3.1.4 Audit standards will be based on published standards of care or operating procedures that have been approved and implemented by YAS.

3.2 National clinical audits will be carried out in line with national criteria standards and the timetables provided by NHS England. The data will be prepared, analysed, and submitted by the CIA team as required. A report of audit outcomes will be shared with CQDF in order to develop any recommendations and actions.

3.3 Local clinical audits will be carried out in line with the agreed standards (3.1.3). Data will be prepared by the CIA team, analysed by the CIA team and the lead clinician and a report produced. Recommendations will be developed by the CIA team and lead clinician which will be presented as part of the report to CQDF for review and agreement on an action plan.

3.3.1 The report will contain the following sections:

- Title - Trust name & logo, document & audit title, name of author, period of data collection & month of publication
- Contents - A list of the report sections with corresponding page numbers
- Summary - A précis of the report
- Introduction - A brief overview of what the audit entailed & the rationale behind its completion
- Methodology - How the audit was created & conducted
- Analysis – Detailed & in-depth outcomes resulting from the audit, relevant graphics/ pictorial representation of results
- Results - Detailed review of the outcomes of the audit
- Conclusion & Overall outcomes and potential impacts of these to the trust
- Action Plan & Recommendations - Using the audit results & conclusions, what, if any, actions, or recommendations have resulted from the audit
- Acknowledgements & glossary - List of acknowledgements, glossary of terms (if required)
- References - List of all references used in creation of the audit using Harvard style
- Appendix - Supporting information as required

3.4 Completed and approved audit reports will be made available to YAS staff via publication on the CIA intranet site.

3.5 All audit procedures will comply with the YAS Data Quality Policy, YAS Records Management Policy and YAS Information Governance Policy.

3.6 Clinical Governance Group (CGG) will receive quarterly reports of completed audits and agreed actions, which will be reported to Quality Committee for assurance.

3.6.1 The Clinical Informatics and Audit Manager will report quarterly to CQDF on progress against the audit plan.

4.0 Training expectations for staff

4.1 Staff undertaking clinical audit are expected to comply with all relevant YAS Policies.

4.2 Support for staff to undertake clinical audit in the role of lead clinician for that audit will be provided by the CIA. It is expected that audit activity will be in line with clinical expertise and training.

4.3 See Appendix A for staff roles and responsibilities.

5.0 Implementation Plan

5.1 The latest approved version of this policy will be posted on Pulse for all staff to view. New members of staff will be signposted to how to find and access this guidance during trust induction.

6.0 Monitoring compliance with this Policy

6.1 The monitoring of this Policy will be the responsibility of the Clinical Governance Group. An annual audit of adherence will be performed by the line manager of the Clinical Informatics and Audit Manager with the results being presented to CGG.

7.0 References

1. NHS England » Clinical audit. https://www.england.nhs.uk/clinaudit/.

2. Health Quality Improvement Partnership. Best Practice for Clinical Audit. at https://www.hqip.org.uk/wp-content/uploads/2020/05/FINAL-Best-Practice-in-Clinical-Audit-2020.pdf (2020).

8.0 Appendices

Appendix A – Roles and Responsibilities

Chief Executive and Trust Board

The Chief Executive is responsible for the statutory duty of quality and takes overall responsibility for this policy.

The Board has a role in driving quality assurance, assessing compliance, commissioning internal audit and thus 'closing the loop' to ensure that reviews and clinical audits are carried out; seeking assurance that improvements have been made.

Quality Committee (QC)

The Quality Committee provides the Board with an objective and independent review of quality, to support the delivery of safety and excellence in patient care. This remit includes a focus on safety, clinical effectiveness, and patient experience.

The Committee enables the Board to obtain assurance that high standards of care are provided, and that adequate and appropriate governance structures, processes and controls are in place throughout the trust.

It is the responsibility of the Quality Committee to:

- Review and monitor delivery of the trust Clinical Strategy and its supporting implementation plans relating to safety, clinical audit and effectiveness and patient experience.
- Review relevant internal and external reports, reviews, and enquiries, in order to support the development of quality within the trust.

Executive Medical Director

The Executive Medical Director has overall responsibility and accountability for clinical audit.

Clinical Governance Group (CGG)

The Clinical Governance Group are responsible for overseeing and steering clinical audit activities and processes. This includes being responsible for:

- the ethical oversight of clinical audit across the organisation
- Approval of completed audits and recommendations/action plans
- agreeing and monitoring implementation of the clinical audit programme/plan.

Clinical Quality and Development Forum

The Clinical Quality and Development Forum are responsible for supporting the development and prioritisation of audits included within the clinical audit programme. The membership of CQDF will support the CIA to identify suitable lead clinicians for local audits.

CQDF will receive reports on progress against the clinical audit programme and will receive audit reports. CQDF are responsible for reviewing these reports, for further developing

recommendations and actions. CQDF will monitor the achievement of actions agreed as a result of clinical audit reports

Clinical Informatics and Audit Manager

The clinical informatics and audit manager is responsible for the implementation of the clinical audit programme, including national reporting.

They are responsible for audit SOP development and the undertaking of quality checks of clinical audits, and for the provision of expert analytics advice to those undertaking clinical audit for the Trust.

They are responsible for recording all clinical audit activity. They will ensure that all staff in the CIA are able to undertake the tasks of data preparation and analysis as appropriate for their role.

Individuals

All staff employed by the trust have a responsibility for the quality of the service which they provide, and all clinically qualified staff are individually accountable for ensuring they comply with audit of their own practice and use audit data to refine their practice in accordance with their professional codes of conduct.