NHS
Yorkshire
Ambulance Service
NHS Trust

Clinical Audit Policy

Document Author: Head of Clinical Effectiveness and Governance

Approved CGG July 2019 to TMG: Dec 2019

Date Approved: December 2019

Document Reference	Clinical Audit Policy May 2019
Version	V3.5
Responsible Committee	Clinical Governance Group
Responsible Director (title)	Executive Medical Director
Document Author (title)	Head of Clinical Effectiveness and Governance
Approved By	TMG in accordance with the Management of Procedural Documents Policy
Date Approved	TMG 11/12/2019
Review Date	Nov 2022
Equality Impact Assessed (EIA)	No Impact
Protective Marking	Not protectively marked

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	J Crossley	D	EIA completed feedback

	2019			Sept 2019 updated format to TMG
3.5.1	Dec 2019	J Crossley	A	Approved by TMG
A = Approved D = Draft				
Document Author = J Crossley Head of Clinical Effectiveness and Governance				
Associated Documentation: Quality Improvement Strategy, Information governance policy: Clinical Audit Guidance and Clinical Audit Programme				

Staff Summary

All staff undertaking clinical audit within YAS will comply with the requirements of this policy.
➢ Registered clinicians are encouraged to undertake clinical audit as part of their registration requirements
➢ Staff will register all clinical audit with the Clinical Informatics and Audit (CIA) team
➢ Patient data used for clinical audit will comply with the YAS information governance policy
➢ All clinical audits will have an index number and will be added to the trust audit programme referenced by that number
➢ All clinical audit results are to be presented to the Clinical Quality Development Forum (CQDF) where recommendations and actions will be discussed
➢ All clinical audit reports will have trust review prior to any external publication
➢ All clinical audits will be reviewed at the CQDF, any trust actions and targeting of resources will be proposed at this group before being forwarded for approval by the Clinical Governance Group (CGG)
➢ The results of clinical audit will be published with trust recommendations on the trust website (PULSE) on the respective CIA page
➢ The trust as a health care organisation has a duty to support clinical audit and to act on the findings as part of its quality assurance and governance processes
➢ All staff are to use this policy in conjunction with the clinical audit procedure (Appendix A)

1.0 Introduction

1.1 Clinical audit it is a way of finding out if healthcare is being provided safely and in line with required standards; it highlights where services are performing well and draws attention to areas where improvements could be made (NHS England, 2018). 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.

1.1.1 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 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 This Policy sets out the trust's legal responsibility as per the NHS Litigation Authority (NHSLA) 2012 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.

2.1.1 Policies/procedures provide a key control measure in the mitigation of risk associated with the undertaking of clinical audit. The trust has adopted the Health Quality Improvement Programme (HQIP) methodology for undertaking and reporting clinical audit https://www.hqip.org.uk/resources/.

2.1.2 HQIP uses the following 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.' (HQIP, Sept 2016, Best Practice in Clinical Audit)

3.0 Process

3.1 The process for undertaking clinical audit is outlined in the clinical audit procedure document (Appendix A).

3.1.1 The process for creating, sign-off and monitoring of the clinical audit programme:

- The draft audit programme is developed by the head of clinical effectiveness and governance following a review of the past years audit and themes and trends from investigations and feedback. It is then shared with the CQDF, 111, EOC and audit team members where further recommendations/proposals are added to the audit programme. The draft audit programme was presented for approval by CGG in March of each year.

3.1.2 The process for monitoring the outputs of the clinical audit programme (2019/20 Programme included as Appendix B):

- The CIA are responsible for reviewing the audit programme monthly and highlighting areas where the programme is not on track.
- A quarterly report will be submitted to CQDF on progress on the audit programme with exceptions and including action plans to meet any deferred audits
- CQDF will report to CGG on the progress and results from the audit programme

4.0 Training expectations for staff

4.1 Support for staff wishing to undertake a clinical audit is via the CIA team, enhanced through the CIA website, accessible via Pulse. This site contains documentation to log an audit and also provides links to the HQIP resources site. The CIA team can help staff form their audit question and standards and provide the access to relevant data as per IG requirements.

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 through audit of its use and adherence to the process. This may be an internal audit or external audit by Audit one as per trust programme. An annual audit of adherence will be performed by the Head of Clinical Effectiveness and Governance with the results being presented year end to CQDF. Where there are areas of non-compliance action plans will be developed by and monitored by CQDF. All monitoring outcomes will be reported to the CGG by CQDF upon completion.

7.0 References

7.1

- Burgess, R. (2011). *New Principles of Best Practice in Clinical Audit.* Abingdon: Health Quality Improvement Partnership (HQIP).
- HMSO. (1998, July). *Data Protection Act 1998.* www.legislation.gov.uk
- HQIP. (2012). HQIP criteria and indicators of best practice in clinical audit & HQIP clinical audit programme guidance.
- HQIP (2016, Sept), Best Practice in Clinical Audit.
- HQIP (2016). An introduction to statistics for clinical audit and improvement
- *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf 2013*
- The Caldicott Committee. (1997). *Report on the Review of Patient Identifiable Information.* London: Department of Health.

8.0 Appendixes

8.1 Appendix A

Clinical Audit procedure 2019 JC.p

Appendix B

CIA Programme 2019- 20 April 19.doc

Appendix C

Roles and responsibilities audit p