CLINICAL AUDIT AND SERVICE IMPROVEMENT POLICY & PROCEDURE

DOCUMENT INFORMATION

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1. INTRODUCTION

1.1 Clinical audit determines whether clinical effectiveness (evidence based practice), patient experience (receipt of compassionate, dignified and respectful care) and patient safety (avoidable harm and risks) are provided in line with the expected standards.

1.2 The process involves disseminating conclusions that inform current and prospective patients, service users, members of the public and stakeholders, whether the service meets these standards and how it could improve its quality.

1.3 Done well, the methods and approach to audit and quality improvement can deliver sustained advancements in the aspects of experience, productivity, and outcomes of care provided and the capacity of those who directly and indirectly contribute to all elements of the Trust business.

2. PURPOSE & SCOPE

2.1. Clinical audit is the NHS organisation's core business and therefore requires appropriate governance within the organisation. The governance is outlined in this policy, and covers the following aspects:

- It sets out responsibilities and expectations and practical guide for all Trust staff proposing, conducting, participating, analysing, reporting and disseminating clinical audit and service improvement.

- It outlines the Trust's expectations concerning staff's training and awareness of the clinical audit and service improvement.

- It provides a reference to a practical guide concerning action plan and ongoing monitoring of the quality of the clinical audit and service improvement processes.

- It sets out an expectation that the Trust involves stakeholders, patients, carers, service users and the general public in the clinical audit and service improvement process.

- It provides assurance links to Clinical Outcome (CO) Ambulance Clinical Quality Indicators (ACQI).

- This policy covers Clinical Audit, National Clinical Quality Indicators and Clinical Benchmarking as outlined in the Clinical Strategy but does not include research covered in the Trust Research Strategy document.

3. EQUALITY STATEMENT

3.1. The Trust is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marriage and civil partnership, disability, race, gender, religion/belief, sexual orientation, gender reassignment and pregnancy/maternity or any other basis not justified by law or relevant to the requirements of the post.

3.2. By committing to a policy encouraging equality of opportunity and diversity, the Trust values differences between members of the community and within its existing workforce and actively seeks to benefit from their differing skills, knowledge, and experiences to provide an exemplary healthcare service. The Trust is committed to promoting equality and diversity best practices both within the workforce and in any other area where it has influence.

3.3. The Trust will therefore take every possible step to ensure that this procedure is applied fairly to all employees regardless of race, ethnic or national origin, colour or nationality; gender (including marital status); age; disability; sexual orientation; religion or belief; length of service, whether full or part-time or employed under a permanent or a fixed-term contract or any other irrelevant factor.

3.4. Where there are barriers to understanding e.g., an employee has difficulty in reading or writing, or where English is not their first language, additional support will be put in place wherever necessary to ensure that the process to be followed is understood and that the employee is not disadvantaged at any stage in the procedure. Further information on the support available can be sought from the Human Resources (HR) Department.

3.5. South Central Ambulance Service (SCAS) takes into account the provisions of the Equality Act 2010 and promotes equality duty within SCAS policies and procedures.

3.6. The Clinical audit and service improvement policy & procedure ensures that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. It is, therefore, requested that any Clinical Audit Proposal Form considers whether the processing will have a positive or negative impact on those with protected characteristics.

4. ROLES AND RESPONSIBILITIES

4.1. The Executive Management Group (EMG)/ Board

4.1.1. The EMG/Board of South Central Ambulance Service NHS Foundation Trust (SCAS) recognises and accepts its responsibilities and leadership obligations to systematically analyse and improve the aspects of experience, productivity, and outcomes of care provided to patients, service users, public and stakeholders.

4.1.2. The EMG/Board commits to heighten awareness of audit and quality improvements amongst all Trust staff, patients, service users, public and stakeholders by publishing transparency notices on the Trust public and staff facing websites and websites that facilitate mandated reporting.

4.1.3. The EMG/Board recognises that environment that welcomes audit and quality improvement initiatives will most likely lead to real improvements. Therefore, the EMG/Board members advocate and empower those conducting audit and quality

improvement projects by having the dedicated time necessary for their conduct and by providing facilities, advice, and expertise to conduct the projects effectively.

4.1.4. The EMG/Board receives reassurances from Quality and Safety Committee (Q&SC), Clinical Review Group (CRG) and Patient Safety Group (PSG) that report and monitor Trust clinical audit outcomes. Clinical Quality Indicators (CQI) are monitored via the monthly Integrated Performance Report and contractual/Clinical Quality Review Meeting (CQRM) mechanisms.

4.2. **Quality and Safety Committee (Q&SC)**

4.2.1. The Q&SC group is chaired by SCAS Non-Executive Director. The Q&SC group receives upward recommendations and contributions from the Clinical Review Group (CRG) with the aim to provide the EMG/Board with assurance that high standards of care are maintained by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

- Promote safety and excellence in patient care
- Identify, prioritise and manage risk arising from clinical care
- Ensure the effective and efficient use of resources through evidence-based clinical practice
- Protect the health and safety of Trust employees.

This includes oversight of the Trust's annual Clinical audit plan.

4.3. **Clinical Review Group (CRG)**

4.3.1. The CRG group is led by SCAS Medical Director and the group members represent SCAS-wide governance structure. The CRG group makes recommendations to the Q&SC group and the EMG/Board.

4.3.2. The CRG group provides a visible and focused leadership ensuring clinical management processes are aligned with the Trust vision. The CRG group concern is also clinical governance over participation in both national and local clinical audits, that are enforced by statutory and contractual requirements for healthcare providers.

4.3.3. An annual Clinical audit plan is agreed and approved by the CRG group and approved and monitored by the Q&SC group. National Clinical Quality Indicators (NCQI), local commissioning requirements and the Trust's Clinical Strategy inform the annual Clinical audit plan.

- National clinical audit programme use the following frameworks:
  - Clinical standards outlined in the NHS Outcomes Framework Clinical Outcome (CO) Ambulance Clinical Quality Indicators (ACQIs)
  - NHS England's Ambulance Quality Indicators Clinical Outcome Specification
  - Clinical performance indicators and clinical benchmarking to drive clinical improvement against evidenced based care and standards
- Trust' own internal clinical audit and improvement programmes that are additional to the mandated national audit programme may use the following guidelines:
  - Clinical practice standards as published by the National Institute for Health and Care Excellence (NICE) guidelines
  - JRCALC Clinical practice guidelines

4.3.4. The CRG group oversees and approves relevant clinical policies and procedures relating to outcomes of these programmes of work.

4.3.5. The CRG group contributes to an annual Quality Account and Improvements report, its related findings and actions as mandated by the Health Act 2009, and on request of the NHS Commissioner it makes available required national and internal clinical audit data to support publications of outcome statistics.

4.4. **Patient safety group (PSG)**

4.4.1. The PSG group is led by SCAS Director of Quality and Patient Care and the group members represent SCAS-wide governance structure. The PSG group reports and makes recommendations to the Q&SC and CRG.

4.4.2. The PSG group ensures an appropriate mechanism are place for action to be taken in response to the results of clinical patient safety audit and the recommendations of any relevant external reports (e.g., from the Care Quality Commission).

4.5. **Senior Clinicians and Leaders**

4.5.1. Senior clinicians and leaders are responsible for the mandated and ad-hoc support of audit and quality improvement initiatives, including of the annual Clinical audit plan and implementation of clinical policies and procedures.

4.5.2. Senior clinicians are responsible for supporting all clinicians within the Trust who are engaged with clinical audit processes and quality improvement, specifically then providing local approvals, contribution to clinical audit proposals, project conduct including analysis and dissemination of learning.

4.5.3. The Clinical Audit team is led by the Research and Clinical Audit manager. The role has the following functions:

- Contribution to the development and monitoring of clinical audit policies and procedures
- Contribution to creating the staff capacity for audit within the trust
- Oversee the clinical audit process within the team and an adherence to audit technical guidance
- Devising and monitoring compliance with the Trusts annual Clinical audit planner, including a production of an annual Clinical audit report
- Promotion of evidence-based practice and organisational learning.

4.5.4. Assistant Director of Quality & Patient Care. The role has the following functions:

- Senior management responsibility for Trust' clinical audit
- Coordinating function between departments to ensure the effectiveness of the Clinical Audit and Service Improvement Policy & Procedure
- Ensuring Clinical Quality Indicators (CQI) are reported via the monthly Integrated Performance Report and contractual/Clinical Quality Review Meeting (CQRM) mechanisms.

4.6. **Every clinical and non-clinical member of staff**

4.6.1. SCAS staff are required to support clinical audit and service improvement initiatives within the Trust and be actively or passively engaged in proposing, conducting, participating, analysing, reporting and disseminating of the project.

4.6.2. It is the responsibility of all clinicians to support quality improvements identified from clinical audit projects and adopt the change, where necessary, to improve the clinical effectiveness, patient experience and safety in line with the expected standards.

4.6.3. It is expected that contribution in clinical audit cycle and service improvement initiatives will feature in the annual discussion of the Continued Professional Development (CPD) review of all staff.

4.6.4. All clinical staff must be made aware of any national clinical quality indicators or learning from clinical audit by way of email or face to face updates as recognised in the Trust' Training Needs Analyses (TNA). All learning from clinical audit is assessed by the Trust' Education Department that advises on the best delivery options and inclusions to the Trust' TNA.

4.7. **Staff performing clinical audits and service improvement projects**

4.7.1. The SCAS staff that are performing mandated clinical audits as part of the national clinical audit programme are required to do so on request, or as part of their Trust role may undertake the following learning so to ensure high quality and accuracy of the audit data and reports produced:

- E-learning on the basics of audit principles (design, planning, audit cycle and implementation of learning) or nationally recognised clinical audit qualification to level 3
- Be familiar with the end-reports Ambulance Quality Indicators (AQI) published by the NHS England (www.england.nhs.uk)
- SCAS staff must be familiar with the technical guidance of each of the mandated audits they are undertaking (NHS Digital: Ambulance Quality Indicators: Clinical Outcomes specification).

4.7.2. The SCAS staff and authorised stakeholders that are performing Trust' own internal clinical audit and improvement programmes may undertake the following learning to ensure high quality and accuracy of the audit data and reports produced:

- Be familiar with the latest guidance on the conduct of audit as produced by the Healthcare Quality Improvement Partnership (HQIP).

The SCAS staff undertaking Trust' own initiatives are required to consult with the Trust' subject matter experts (SME) such as the research and clinical audit manager and clinical audit facilitators, information governance managers, business intelligence analysts, communications team and any other relevant stakeholder to ensure the project' effective oversight considers and includes the following:

- Consult on the best suited methodology and design of the project to effectively address each of the audit or quality improvement questions and targets
- Consult on completion of the Clinical audit proposal form (Appendix 1)
- Consult on the adherence and compliance with the privacy laws including UK GDPR 2021 and Data Protection Act 2018 to prevent breaches of these laws
- Consult on receiving appropriate permissions and access to data in a timely manner
- Consult on storage locations of the raw and processed data, and the data life cycle (deletion) to manage risks effectively and prevent data breaches and unauthorised access
- Receive permission and guidance on how best to involve Trust' patients, carers, service users, stakeholders and the general public in the clinical audit and service improvement process, where able to do so
- Consult on ethical implications of the project, however, note that Research Ethics Committee (REC) approval is not required
- Receive permissions to share processed data, the audit outcomes and service improvement results with selected groups or shareholders group. Note, any Trust data, project outcomes and results are sensitive Trust intelligence data
- Receive permissions to use Trust-wide dissemination channels to ensure wider learning from the project outcomes, including the next steps actions

- Receive support in terms of adequate time, equipment and workforce resource to carry out the project effectively to time and target. Staff are prohibited from use of their own personal PC to process Trust data
- Ensure the project enters the annual Clinical audit plan which indicates that the Trust agrees with the methodological and ethical criteria and accepts risks of the project, and that it allows for patient data to be accessed and analysed.
- Receive permission to start the project as it is prohibited to process any Trust data without appropriate permissions
- Produce a report when the audit is concluded that summarises the audit aims & objectives, standards referenced, sample, method, findings and recommendations. This will be shared with the clinical audit team who will mark the audit as complete on the annual Clinical audit plan and advise on onward dissemination
- Ensure that all audits on the annual Clinical audit plan are summarised in the Trust's annual Clinical audit report.

4.7.3. All SCAS staff undertaking clinical audit and service improvement projects are required to complete an annual Information Governance training and certification prior to any engagement with the Trust data and their processing.

5. PRACTICAL GUIDE FOR AUDIT AND SERVICE IMPROVEMENT

5.1. Clinical audit and quality improvement activities are interconnected and have a cyclic model (Diagram 1). It is important to highlight that clinical audit is only one of a range of quality improvement methodologies and should not be used if another is more appropriate to answer the questions set to address. The Healthcare Quality Improvement Partnership (HQIP 2020; www.hqip.org.uk) provides a useful guidance to quality improvement processes https://www.hqip.org.uk/wp-content/uploads/2021/01/Final-Quality-Improvement-QI-Tools-09-12-20.pdf.This guidance and the HQIP website also offers further reading list and additional directions and instructions.

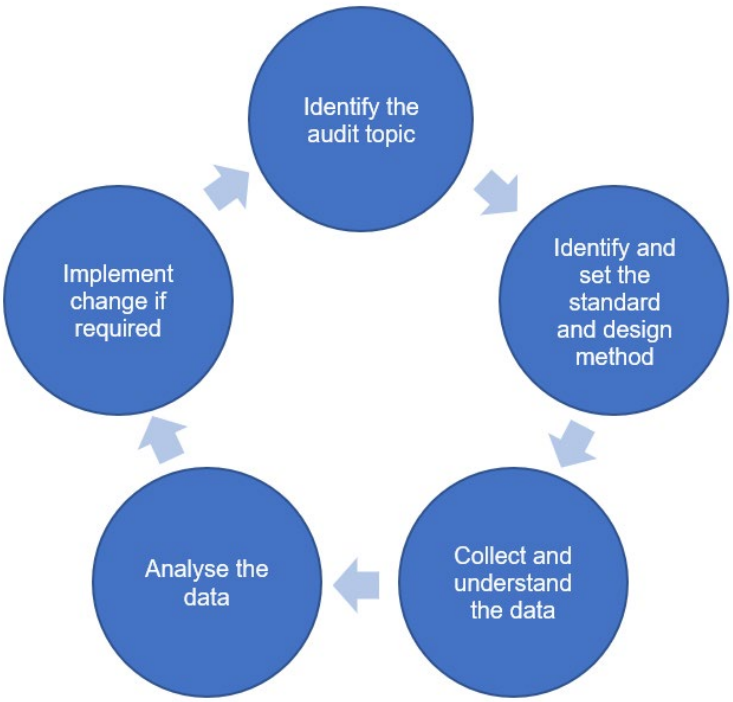

Diagram 1. General audit cycle

6. NATIONAL CLINICAL QUALITY INDICATORS

6.1. The Ambulance Quality Indicators (AQIs) were created to provide an overview of the clinical quality achieved by ambulance services. The purpose of the Clinical Outcomes Technical Guidance document is to provide a detailed description of each of the Clinical Outcome (CO) Ambulance Quality Indicators (AQIs), including clarification on aspects of the sampling process, data sources, data collection and analysis methods. These will be referred to as CQI's in the document. The guide should be used in conjunction with NHS England's Ambulance Quality Indicators Clinical Outcome Specification.

6.2. There are four CQI topic areas and each of these has specific clinical process and outcome measures:

- Cardiac Arrest
- ST Elevation Myocardial Infarction (STEMI)
- Stroke
- Sepsis.

These focus areas may change and develop in line with national guidance.

6.3. The Clinical Outcomes Technical Guidance outlines the basic principles that apply to the CQIs areas in general and contains the detailed descriptions of the measures within Identify the audit topic Identify and set the standard and design method Collect and understand the data Analyse the data Implement change if required each area and the methodologies required by which the data must be collected and analysed.

6.4. Data relating to national CQI are processed using the relevant Trust' informatics and clinical audit software and systems and/or national registry system, as required by individual CQIs. National registry and reporting systems include:

- The Warwick Out of Hospital Cardiac Arrest Outcomes Registry (OHCAO)
- The NICOR Myocardial Ischaemia National Audit Project (MINAP)
- The Sentinel Stroke National Audit Programme (SSNAP)
- The NHS Strategic Data Collection Service (SDCS).

6.5. Data will be used by NHS England to present performance data for the Clinical Outcome component of the AQIs and as part of a Balanced Scorecard. The Public may access this information through individual Trust websites and NHS England. Ambulance Trusts may also use the CQI data to monitor and improve their own clinical quality, including benchmarking against other Trusts.

7. MONITORING

7.1. The Policy is monitored for its effectiveness by the CRG, Q&SC and PSG groups through the following:

- Responsibilities of staff will be monitored through attendance at meetings, management of systems, development of reports and the appraisal process
- The clinical audit activity will be monitored by the Clinical Audit Department and produce an annual report to the Quality and Safety Committee covering the number of audits undertaken and summarising findings and recommendations.

APPENDIX 1

Many of SCAS policies have an ‘Internal staff form’ attached that is relevant to the document. The ‘Clinical Audit Proposal Form’ is included with this policy but for security and accessibility reasons it is only available on SCAS Staff Intranet.