



SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST

CLINICAL SERVICES POLICY & PROCEDURE (CSPP No.20)

CLINICAL AUDIT POLICY & PROCEDURE

April 2019

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4

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**SOUTH CENTRAL AMBULANCE
SERVICE NHS FOUNDATION TRUST**

**CLINICAL AUDIT
POLICY AND PROCEDURE**

1. Introduction

- 1.1 Clinical Audit has been approved and implemented by the Trust Board who recognise and accept the need for a Clinical Audit policy as part of its Clinical Governance.
- 1.2 The Trust Board have the ultimate responsibility to take all measures within their power to ensure the Clinical Audit policy is implemented throughout the Organisation and provide a supportive organisational culture for clinical audit. This responsibility will be delegated to the Medical Director.
- 1.3 Clinical audit also includes clinical performance indicators and clinical benchmarking audits to drive clinical improvement against evidenced based care.

2. Policy Statement

- 2.1 The Trust Board of South Central Ambulance Service NHS Foundation Trust recognise and accept its responsibilities to systematically analyse the care and treatment provided to patients by the Organisation, through the use of Clinical Audit and to heighten awareness amongst staff throughout the Trust of the importance of Clinical Audit in this respect.

3. Scope of the Policy

- 3.1 Clinical Audit can be defined as:

“the systematic critical analysis of the quality of clinical care, including the procedures used for diagnosis, treatment and care, the associated use of resources and resulting outcome, and quality of life for the patient.”

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

4. Duties

4.1 Medical Director

The Medical Director has Board level responsibility for clinical audit within South Central Ambulance Service NHS Foundation Trust. The Medical Director is a member of the Clinical Review Group with responsibility for clinical audit.

4.2 Assistant Director of Patient Care

The Assistant Director of Patient Care has senior management responsibility for clinical audit. The role also has a co-ordinating function between departments to ensure the effectiveness of the policy.

4.3 Clinical Review Group

The Clinical Review Group will assess the effectiveness of the policy and provide a gap analysis and action plans for the Quality and Safety Committee to monitor.

4.4 Quality and Safety Committee

The Quality and Safety Committee will monitor the clinical audit activity within the Trusts clinical governance structure. The Quality and Safety Committee will monitor clinical audit activity on behalf of the Trust Board.

4.5 Clinical Audit Facilitators

The Clinical Audit Facilitator will contribute to the implementation of the Trust's Clinical Strategy, through the proactive delivery of high quality, innovative and effective Clinical Audit as part of the Clinical Audit and Effectiveness programme. This includes:

- working closely with others in the Clinical Audit and Effectiveness department, R&I department, and Health Informatics to deliver the organisation's Clinical Audit and Effectiveness Programme within agreed timescales
- undertaking clinical audit and other quality improvement projects to measure existing practice against local and national guidelines and standards of practice
- assisting others to undertake audits by providing clinical audit, methodology advice and support across the organisation as required
- writing audit reports, associated documents, and ad-hoc reports
- effective communication with a wide range of people
- maintaining the confidentiality and security of patient records

4.6 All Staff

All staff have a duty to participate in clinical audit in line with this policy, clinicians will be expected to follow this policy and procedure, participate in data collection and accurately complete patient clinical records for Clinical Audits to be undertaken by the Organisation.

All staff have a duty to engage themselves in the continuing need for the spread of best practice and the need to further improve patient services and patient care. To undertake audits in their work place, which will lead to, sustained quality improvements in service delivery by sharing results to their immediate colleagues.

5. Clinical Audit Procedure

5.1 The Organisation is committed to improving the quality and outcome of patient care by implementing a process of Clinical Audit throughout the Trust. An annual Clinical Audit Plan will be agreed and approved by the Clinical Review Group and approved and monitored by the Quality and Safety Committee. National Clinical Quality Indicators, local commissioning requirements and the Trusts Clinical Strategy will inform the clinical audit annual plan.

5.2 The aim of Clinical Audit is to improve patient care through a systematic analysis of the quality of health care including procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of patient life after treatment.

5.3 The manager for Clinical Audit in the Organisation will be the Assistant Director of Patient Care

5.4 The Lead Audit Analyst and Team Leader will be Responsible for accurate and timely data input and retrieval as requested by the Assistant Director of Patient Care.

The senior Audit Facilitator will be responsible for reviewing, collating audit data and providing second line verification of all audit data for inclusion and exclusion from audits.

5.5 In preparing the Organisation's Clinical Audit documentation, the Assistant Director of Patient Care will employ the following Best Practice criteria when assessing a clinical audit project;

A Design

- Involve stakeholders
- Select a subject to audit from audit request received
- State objectives
- Use explicit measures
- Reflect best practice
- Define case selection

B Measures

- Test validity and reliability of data
- Evidence base standards
- Create environment/cultural aspects to facilitate the audit
- Respect ethics and confidentiality
- Analyse audit data

C Evaluate

- Present audit data
- Identify shortcomings and their causes
- Identify improvements
- Devise strategy for action
- Implement action.

D Repeat for Improvements

- Re-audit

5.6 All requests for Organisational involvement in a Clinical Audit are to be reported on the South Central Ambulance Service NHS Foundation Trust Clinical Audit Proposal Form. *Appendix 1.*

5.7 The Clinical Audit Proposal Form is to be completed fully for each Clinical Audit project undertaken by the Organisation.

5.8 A Clinical Audit Proposal Form is to be initiated by the individual receiving any external request for the Organisations involvement in a Clinical Audit, and should be completed in all cases.

5.9 Immediately on completion, the Clinical Audit Proposal Form is to be forwarded to the Assistant Director of Patient Care who will scrutinise the proposal to assess the suitability of the audit.

5.10 The Assistant Director of Patient Care is responsible on behalf of the Organisation for the selection and prioritisation of audits within the current agreed Clinical Audit programme.

5.11 The Assistant Director of Patient Care is responsible for informing the applicant of the Organisations decision.

6. Partnership Working

6.1 The Assistant Director of Patient Care will work in partnership with other healthcare professionals and NHS Trusts by;

- Gaining membership in local Ambulance Clinical Audit Networks/Groups on behalf of the Trust.

- Joining multi Trust Clinical Audit Networks/Groups with membership of Clinical Care Groups (CCG's), Acute Trusts and National groups.
 - Form links with specialist paid and voluntary Organisations working as an authority on specific patient conditions, e.g. Stroke Association.
- 6.2 The aim of partnership working is to improve the patient pathway by smoothing patient care across the care boundaries and identifying by clinical audit areas that can be targeted to achieve this.
- 6.3 The Trust will work in partnership with commissioners to audit quality measures as agreed in the quality schedule monitored at the Clinical Quality Review Meetings (CQRM's) at least bi-annually or as agreed.

7. National Clinical Quality Indicators

- 7.1 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 (appendix 3) 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 for data from April 2018.
- 7.2 There are five CQI topic areas and each of these has specific clinical process and outcome measures:
- Cardiac Arrest
 - ST Elevation Myocardial Infarction (STEMI)
 - Stroke
 - Sepsis
 - Falls in older people
- 7.3 Section 1 outlines the basic principles that apply to the CQIs areas in general. Section 2 contains the detailed descriptions of the measures within each area and the methodologies required by which the data must be collected and analysed.
- 7.4 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.

8. Clinical Audit Development

- 8.1 The Trust is committed to developing clinical audit with initiatives that become available with the development of technology and shared practice.
- 8.2 The Trust will move towards electronic data collection and analysis as a means to improve the speed and accuracy of data collection and analysis.
- 8.3 This in the short term will be based on the availability of private sector technology as used in other NHS Trusts to satisfactory results. All possible advances in the technology will be installed as and when available in order to maintain the advances gained.
- 8.4 The future is to integrate into the HL7 / FHIR interface to transmit data to acute trusts so as a full clinical record integration can be achieved. The Assistant Director of Patient Care will work with the Trusts IT department to ensure the best solution is available.

9. Monitoring

- 9.1 The Policy will be monitored for its effectiveness by the Assistant Director of Patient Care 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 Effectiveness Department and a report produced bi-annually to the Quality and Safety Committee covering:
 - The number of audits undertaken;
 - Compliance with procedure;
 - an audit of clinical record completion will be carried out bi-annually to ensure compliance by minimum completion where appropriate of:
 - Care given in line with JRCALC guidance;
 - Incident details;
 - Clinical observations.

These will be conducted on a bi-annual basis and reports provided to the Clinical Review Group and Quality and Safety Committee.

10. Training

- 10.1 Clinical Audit Facilitators will have a nationally recognised clinical audit qualification. The course will cover audit design and planning, the audit cycle and implementation of learning. The course will be accredited to level 3.
- 10.2 All clinical staff will be made aware of any national clinical quality indicators or learning from clinical audit by way of updates by email or face to face as recognised in the Trusts Training Needs Analyses (TNA). All learning from clinical audit will be assessed by the Trusts Education Department to advise on delivery options where appropriate added to the TNA.

11. Other references

Data Protection Policy
Care Pathways Policy
Resuscitation Policy
Child and Vulnerable Adult Protection Policy
Training Needs Analyses

Appendix 1

Clinical Audit Proposal Form



**South Central Ambulance Service NHS Foundation Trust
 Clinical Audit Proposal Form**

Audit Title:			
Audit Requester:	Name: Title/Role: Base Location: Email: Phone:		
Rationale for audit:	<input type="checkbox"/> Audit against guidelines/ standards <input type="checkbox"/> Linked to PALS enquiry <input type="checkbox"/> Linked to Complaint	<input type="checkbox"/> Serious Incident <input type="checkbox"/> Area of high risk (please give rationale for assessment as such) <input type="checkbox"/> Area of high cost <input type="checkbox"/> Area of high volume	<input type="checkbox"/> Other (please specify)
	<p>Please give as much detail as possible including: audit description/ specific standards to be measured/ reason audit request arose e.g. enquiry/ complaint/risk, etc. / include any potential changes to clinical practice.</p> <p>After distribution of the management plan results could be re-audited a year later to establish the effectiveness of the guidelines or recommendations.</p>		

Please send completed proposal to: clinical.audit@scas.nhs.uk
All proposals will be reviewed by the Clinical Review Group

Name:

Signature:

Date:

If you have any queries regarding the completion of this form please contact:

Sue McGreevy
Clinical Audit Facilitator

Office: 01962 898164
Email: sue.mcgreevy@scas.nhs.uk

Clinical Audit Proposal Form V2 September 2018

Appendix 2

Clinical Audit Report Form/Action Plan



(Re-)Audit title

Service(s)

Area(s)

Disciplines involved i.e. Call Handlers, Paramedics etc.

Project team	
Name of project lead:	Job Title:
Name:	Job Title:
Name:	Job Title:
Name:	Job Title:
Data period:	
Report completion date:	

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Executive summary

The executive summary should include a summarised version of the background and rationale to the project, the main aims and objectives, key findings and recommendations.

(This should be written after the report has been completed)

Background

Briefly describe the reasons for undertaking this audit/survey.

E.g. The area has been the subject of recent clinical incidents

Following a previous audit, actions were implemented to improve practice and a re-audit is now required

An audit is required to ensure adherence to new clinical guidelines following their implementation

Aim

State what you need the audit to tell you/what you hope to identify. The aim is the goal you wish the audit/survey to achieve.

E.g. Has the recent change in practice improved compliance with the evidence base?

Is a particular practice compliant with NICE guidance?

Objectives

Identify how you will conduct the audit/survey project to address the aim. Objectives should be identified from the outset of the project and SMART; specific, measurable, achievable, realistic and timely.

Standards/guidelines/evidence base

What standards and guidelines have you compared against? What criteria have been used? Please specify the full title, reference and source of the criteria.

Sample

Which patients are you identifying and from which time period has the sample been selected?

E.g. All patients with chest pain and diabetes during the 3 month period from 1st May 2018 to 31st July 2018 were included in the audit.

Specify the total sample size/population and detail how you achieved the sample selected (methods) and include justification for your sample size e.g. inclusion/exclusion, random sample, stratified sample etc.

Describe how you identified your sample;

E.g. All patients discharged at scene from 1st May 2018 to 31st May 2018

Data source

Which data are utilised in the audit/survey?

E.g. health records, x-ray reports, clinical management system, patient survey, observational, etc.

Audit type

Specify if your project is criterion, indicator-based, patient survey, etc.

If you are unsure of the audit type please contact your Clinical Audit Lead or the Clinical Effectiveness team.

Methodology

This is a national, regional, local, (*delete the not applicable ones*) audit/survey.

Describe how the audit/survey was undertaken, this should be written in narrative format (including bullet points where required) and the following should be considered:

- developing and piloting a data collection tool - add this to the appendix
- data collection
 - how data was obtained e.g. EPR/CARS/Qlikview/Vehicle running log etc
 - prospectively/retrospectively
 - who collected the data e.g. paramedic, admin etc.
- data validation – how was the data validated, explain how this was completed and by whom
- data analysis
 - detail the packages used, e.g. Datix /EPR/Qlikview
 - you may wish to include whether the data analysis was validated and by whom e.g. in order to validate the data a draft set of findings were produced and checked/randomly checked by a second facilitator for accuracy.
- report writing (*detail who completed the report including their job title*)

Remember, each aspect of the methodology should detail the member(s) of staff responsible.

The description of the methodology should be sufficient to allow the audit/survey to be replicated by someone who had no previous involvement or knowledge of it.

Findings

Initially state your “N” number; N represents the total number of cases identified as the representative sample for inclusion in the audit/survey.

E.g. 50 cases were identified for inclusion in the audit of thromboprophylaxis, thus N=50.

Fluctuating N: Please note that the N may fluctuate, which can be shown by using “n”.

E.g. Standard: All patients should receive drug A.

Exceptions: Patient has a contraindication to drug A or is already prescribed it.

Note: 5 cases were exceptions. (In 3 cases patients were already prescribed drug A and in 2 cases there was a contraindication to drug A.) therefore, the n will be 45.

The standards used should be highlighted in bold. Compliance against the standard should be detailed below to include the number and percentage of compliance.

Present data in table format where possible (this is usually sufficient for most audits/surveys).

E.g. Standard: The following signs should be recorded on admission (N=51):

Criteria	Adherence	
		(%)
<i>Heart rate</i>	50	(98%)
<i>Respiratory rate</i>	50	(98%)
<i>Temperature</i>	48	(94%)
<i>Blood pressure</i>	45	(88%)

Be selective with the use of charts, remembering to use the most appropriate method to present the data e.g. pie charts to show proportions and bar charts for easy comparison between different areas/time periods.

Individual clinicians/sites/practices etc. should not be identified within the report, when presenting this data the following format should be used:

Clinician 1

Clinician 2 etc.

If required, individuals could be informed of only their own identifier before or after the presentation.

Patient identifiable data e.g. surname, date of birth, NHS number, hospital number etc should never be included in a clinical audit report.

Discussion of Findings

What overall observations can be drawn from your findings? Detail any key themes arising from the analysis of data. Ensure your observations are supported by the project findings and include the key points.

Definitions of good practice and areas of practice requiring improvement should be determined by the project team (if used).

Areas of good practice:

- All asthmatic patients were given a yearly review.
- 90% of people with schizophrenia had their physical health monitored by a GP or primary healthcare professional at least once a year.

Areas for improvement:

- Only 50% of patients with schizophrenia had documentation to confirm they were routinely monitored for coexisting conditions.
- The doctor's signature was present on the consent form in only 75% of cases.

Suggested Methodology/Process Changes

Include any problems identified related to the audit methodology and process of the audit which may need to be addressed/considered before undertaking a re-audit.

E.g. difficulties with identifying the patient sample, required updates to the proforma

(If there are no changes identified this section can be deleted)

Recommendations

Recommendations should be made and based on the findings and any other relevant finding identified during the course of undertaking the clinical audit project.

E.g. An audit of consent in radiology identified a process where consent forms were scanned onto a system; some staff were not scanning the whole consent form.

Incorporate SMART (Specific Measurable Achievable Realistic Timely) principles in all recommendations.

All recommendations in the clinical audit report should be numbered and mirrored in the action plan.

Presentation

Include information on where and when the project was presented and action plan discussed and agreed

References

Where applicable detail any references (e.g. references quoted in the Background/ rationale section) in Harvard format.

E.g. NICE (March 2009). Clinical Guideline 82: Core interventions in the treatment and management of schizophrenia in primary and secondary care (update).

- Do not detail any references already detailed in the Standards/guidelines/evidence base section
- References to previous audit reports should also be included here

E.g. St Elsewhere Primary Care Trust (January 2011). Audit of asthma management in paediatrics (Project number 111)



Action Plan

Source of Action Plan	SIRI/ High Risk Incident/ Complaint/ Claim/ Audit
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Title	Ensure this is exactly the same as the title detailed on the front cover	Ref/Project No.
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Action Plan Lead	Name:	Title:	Contact:
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Ensure that the recommendations detailed in the action plan mirror those recorded in the “Recommendations” section of the report. The “Actions required” should specifically state what needs to be done to achieve the recommendation; there may be more than one action per recommendation. All updates to the action plan should be included in the “Comments” section.

Recommendation (number only)	Action Required (specify “None”, if none required)	Action by Date	Person Responsible (Name and title)	Comment/ Action Status (Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc)	Change Stage (see Key)	Date Action Completed	Evidence of Completion and where stored

KEY (Change status)

- 1 Recommendation agreed but not yet actioned
- 2 Action in progress
- 3 Recommendation fully implemented
- 4 Recommendation never actioned (please state reasons)
- 5 Other (please provide supporting information)