



London Ambulance Service **NHS**
NHS Trust

The Strategy, Process and Application of Clinical Audit in the London Ambulance Service

DOCUMENT PROFILE and CONTROL.

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26/03/18	4.1	IG Manager	Minor amendments required for PMAG approval and Document & Profile Control update
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23/09/15	3.2	Head of Clinical Audit & Research; Clinical Audit Manager	Names of committees and departments updated, Appendix 2 updated
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10/09/10	0.1	Head of Clinical Audit and Research & Assistant Head of Clinical Audit & Research	New document

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1. Introduction

This document is intended to describe the strategic approach and the process of clinical audit in the London Ambulance Service NHS Trust (LAS). It aims to ensure that clinical audit is of a high standard; relevant to the Service and our patients, and that the findings are practically applied to improve clinical care and patient outcomes.

2. Scope

This document applies to all Trust employees, contractors and third parties wishing to undertake clinical audit in the LAS, plus those interested in the clinical audit and quality improvement functions of the LAS. Clinical audit is the responsibility of all staff, although it is largely undertaken by clinicians and those within the Clinical Audit and Research Unit (CARU).

3. Objectives

The objectives of this document are to:

1. Inform the LAS's approach to clinical audit including its strategy, process and application
2. Outline the direction and steering of clinical audit activities
3. Support the strategic direction outlined in the Service's Clinical Strategy
4. Guide the development of the annual clinical audit programme including topic selection, prioritisation, audit methodology and equality factors that will be considered
5. Demonstrate that best practice standards are used when auditing clinical practice
6. Describe the process by which the LAS will take action to improve clinical quality and patient care as a result of clinical audit
7. Illustrate how clinical audit findings will be communicated, internally and externally, to enable improvements through sharing information
8. Outline the multidisciplinary approach to clinical audit by involving a range of staff, external clinicians, academic partners, patients, the public and other relevant key stakeholders
9. Describe how clinical audit activity will be monitored and evaluated
10. Outline the resources, training and support available to those involved in clinical audit.

4. Clinical Audit in the LAS

Clinical audit is a quality improvement process that 'seeks to improve patient care and outcomes through a systematic review of care against explicit criteria and the implementation of change' (National Institute for Clinical Excellence, 2002)¹. The overall objective is to improve patient care by informing healthcare professionals about their clinical practice and recommending improvements where required.

The LAS recognises that clinical audit is an invaluable driver to clinical improvement, and is committed to undertaking a programme of clinical audit to ensure the highest standards of care, improve clinical quality and patient outcomes, and minimise clinical risk.

The strategic aims of clinical audit in the LAS are threefold:

1. To achieve demonstrable improvements in clinical quality and the delivery of patient care
2. To encourage evidence-based practice
3. To contribute to the process of continuing clinical education.

In order to facilitate the delivery of robust and systematic clinical audit, the LAS will aim to:

- Participate in local and/or national clinical audit
- Set a clinical audit programme related to both local and national priorities, with the main aim of improving patient outcomes
- Work collaboratively and engage appropriate stakeholders
- Raise awareness amongst clinicians of the systems and arrangements for participating in clinical audit
- Provide suitable training and support to all staff involved in clinical audit and facilitate completion of the audit cycle
- Evaluate the clinical audit programme to ensure that it: meets the LAS's strategic aims and objectives; the needs of our staff and patients; is fit for purpose, and efficiently uses resources
- Provide regular progress reports, findings and recommendations to the Trust Board and other relevant committees.

¹ National Institute for Clinical Excellence (2002). *Principles for best practice in clinical audit*. Radcliffe Medical Press Ltd

5. Responsibilities

5.1 Trust Board

Ultimate accountability for clinical audit lies with the LAS Trust Board.

5.2 Executive Group

QOG in turn reports to the Exec Group and will submit to the Board any matters requiring Trust Board approval under the Trust's Scheme of Delegation and Reservation.

5.3 Quality Oversight Group

The Quality Oversight Group is chaired by the Chief Quality Officer, with the Head of Clinical Audit & Research as a member. This group oversees several subgroups who contribute to the Trust's Quality Agenda, ensures workplans are aligned to the Trust's objectives and escalates any concerns to the Executive Group.

5.4 Clinical Effectiveness and Standards Group (CESG)

This committee, which meets bimonthly, is chaired by the Deputy Director of Clinical Education & Standards (who is also a member of CARSG). The Clinical Effectiveness and Standards Group monitors the LAS's clinical audit function to ensure clinical learning is embedded as part of the Trust's continuous quality improvement cycle and submits written reports to the Quality Oversight Group. The Head of Clinical Audit & Research sits on this committee and provides regular reports on the progress of the clinical audit work programme and clinical audit outcomes. CESG also actively monitors the implementation of clinical audit recommendations to ensure high standards of clinical quality and the delivery of improvements to patient care.

5.5 Clinical Audit and Research Steering Group (CARSG)

This multidisciplinary group is chaired by the Medical Director and is responsible for setting and approving the clinical audit programme, as well as monitoring the appropriateness of the programme throughout the year and taking action where necessary. It also reviews the results of clinical audit projects and advises on the development and implementation of clinical audit recommendations to ensure that they are measurable, achievable and realistic, with the potential to improve patient care. The Terms of Reference for CARSG are reported in Appendix 2 of this document. CARSG reports to the Clinical Effectiveness and Standards Group.

5.6 Medical Director

The Medical Director is a member of the Trust Board who maintains overall responsibility for the clinical audit function of the LAS.

5.7 Head of Clinical Audit & Research

Through involvement at a strategic level both internally and externally (at national clinical audit and quality groups), the Head of Clinical Audit & Research is responsible for shaping the clinical audit programme to ensure that it meets the needs of the Service and, where possible, the wider NHS. The Head of Clinical Audit & Research leads the clinical audit programme, overseeing the conduct and reporting of all projects to ensure a high standard and a focus on demonstrable changes to clinical quality and patient care.

5.8 Clinical Audit Manager

The Clinical Audit Manager is responsible for the co-ordination of the clinical audit programme and the implementation of arising recommendations. The Clinical Audit Manager is also responsible for delivering the LAS's clinical audit approvals process and monitoring the progress of active clinical audit projects.

5.9 Risk Lead

The Medical Director is ultimately responsible for managing risks associated with clinical audit in the LAS and ensures that relevant areas of clinical risk are examined through the clinical audit programme.

5.10 Clinicians

Registered paramedics must be able to assure the quality of their practice by engaging in evidence based practice systematically and participating in audit procedures². All clinicians contribute to clinical audit projects, either by ensuring the submission of the necessary data and paperwork, or by undertaking clinical audit projects themselves. Team Leaders have a defined audit function, whereby they are responsible for undertaking a specific programme of clinical audit known as the Clinical Performance Indicators.

6. The Approach to Clinical Audit

The LAS works on the assumption that all practitioners can and do have ideas for improving the Service, and is keen to ensure that clinical audit is a process that is

² Health & Care Professions Council. (2014) *Standards of proficiency: paramedics*. 3rd ed. London: Health & Care Professions Council.

open to all staff, regardless of whether or not they have prior clinical audit experience. As such, although the majority of clinical audit work is undertaken within CARU, staff from across the Service are actively encouraged to participate in clinical audit. Furthermore, those involved in clinical audit may not always be LAS employees; they may work for other NHS Trusts, academic institutions and commercial organisations.

In order to avoid duplication of effort and ensure that resources are directed towards projects aligned with the needs of the Service, any non-CARU LAS staff or those from external organisations wishing to undertake a clinical audit that utilises LAS resources, staff, or data must first seek LAS approval prior to commencing the project. In such instances, individuals will be required to submit to CARU an audit proposal that will be reviewed for consideration of appropriate methodology, potential LAS resource implications, and coherence with the clinical audit programme and LAS priorities. If approval is not granted, then the project cannot be undertaken within the LAS or use our data. Regardless of who is undertaking the project, all clinical audit activity will be monitored by CARU, and guided to ensure that recommendations are realistic and derived from the findings. CARU will also assume responsibility for monitoring recommendations relevant to the LAS to ensure the delivery of improvement to clinical care. See Appendix 3 for Volunteer Plan.

Quality of care will be measured in many ways including: adherence to clinical guidelines; improvement in or maintenance of condition; health outcome; appropriate delivery to another care provider; speed of response, and patient satisfaction. Appropriate measures will be selected at the outset of each audit, with emphasis on including patient-focused outcomes where possible.

Any ethical or governance concerns identified by individuals whilst conducting or reviewing clinical audits will be escalated to the appropriate clinical lead (Sector Governance Leads, Safeguarding Team and/or Medical Directorate) and acted upon in accordance with best practice.

Using the results of clinical audit, recommendations for enhancing patient care will be developed, which will be widely disseminated to help inform pre-hospital clinical guidelines and training programmes, and raise awareness and understanding of certain clinical issues amongst staff. Recommended changes may be implemented at an individual, team, or Service level and further monitoring (re-audit) will be undertaken to confirm improvement in practice and patient care.

A programme of clinical audit activity will be set annually under the guidance and approval of CARSG, and monitored by the Clinical Effectiveness & Standards Group. The clinical audit programme will aim to address corporate priorities and complement other LAS quality improvement initiatives and, as such, will link closely with the LAS strategic plan (which forms the direction of travel for the Trust) and the following areas:

- Research and Development
- Clinical and Quality Directorate

- Education and Development (Training and Clinical Supervision)
- Patient and Public Involvement
- Governance and Compliance
- Business Development
- Control Services (Emergency and Urgent Operations Centres)
- Patient Experiences
- Legal and Risk Services
- Equality and Inclusion
- Information Management and Technology
- Finance and Corporate Processes

Prior to undertaking each clinical audit project stakeholders and their engagement within the clinical audit will be identified.

7. Direction and Steering

The position of clinical audit within the LAS's organisational structure is illustrated in Appendix 1. The clinical audit programme will be agreed and overseen by CARSG, a group that meets bi-annually and is chaired by the LAS's Medical Director, with interim updates provided between meetings. This multidisciplinary group consists of internal and external members, including representatives from Education and Development, Control Services, frontline operational staff, A&E clinicians, other specialist clinicians, academic partners and patient representatives (via the LAS Patients' Forum). CARSG reports to the Clinical Effectiveness & Standards Group, which in turn reports to the Quality Oversight Group and the Trust Board.

As the function of CARSG is shared between clinical audit and research, its Terms of Reference (Appendix 2) are relevant to both the clinical audit and research programmes. The main objectives of CARSG specifically in relation to clinical audit are:

- To set the priorities and goals for clinical audit in relation to short and long term objectives, and to approve the clinical audit programme
- To ensure that clinical audit results, recommendations and supporting action plans are reported widely and appropriately
- To ensure that recommendations are recognised and acted upon by the LAS
- To provide practical support to LAS clinical audit functions
- To ensure there is rigorous scrutiny and review on a regular basis
- To approve this document.

In addition to the above objectives, CARSG will monitor progress to ensure that clinical audit in the LAS:

- Follows the process and philosophy set out in this document
- Adheres to the priorities of the LAS strategic plan, Clinical Strategy, other key strategies, key performance indicators and governance frameworks
- Maintains an educational role by including a variety of operational, training and managerial staff on audit advisory groups
- Conducts re-audit following the implementation of recommended actions to demonstrate improvements to practice and patient care.

8. Programme Strands

8.1 Topic Selection and Prioritisation

At the beginning of each year we will select a number of topics for clinical audit using the Trigger List (Appendix 4). Use of the Trigger List will ensure that the clinical audit programme is responsive to the objectives of the LAS, the wider NHS, and pre-hospital care in general. Selected topics will form the basis of the clinical audit programme. Each topic will be prioritised in order of importance to the LAS using the Selection and Prioritisation Tool (Appendix 5). We will produce a clinical audit programme that will be presented to CARSG for their input and approval. CARSG will review progress against the programme quarterly and progress will be reported to the Clinical Effectiveness & Standards Group following each CARSG meeting. In between CARSG meetings, there will be 'mid-point review' meetings where the Chair of CARSG will meet with the Head of Clinical Audit & Research, the Assistant Head of Clinical Audit & Research, the Research Manager, the Clinical Audit Manager and the R&D Co-ordinator to review progress against the work plan, review the prioritisation of projects and re-prioritise as appropriate in response to new information on already selected projects, new topics and prospective adopted projects. At these meetings the protocols for individual clinical audit projects will also be discussed.

8.2 Types of Audits

Clinical audit projects will be carried out in different ways as described below, using the latest available evidence on design and methodologies.

8.2.1 Baseline Clinical Audits

This type of audit provides a systematic clinical review of an area of care to identify whether or not there is a need for further in-depth clinical audit. It is essentially a short, focussed insight into an area where there is a suspected quality concern. Where the concern is confirmed and a need for further audit identified, a snapshot or large-scale clinical audit will be undertaken.

8.2.2 Snapshot Clinical Audits

Snapshot clinical audits examine specific aspects of care either within a particular geographical area of the LAS, or a specific group of patients. These focused audits examine a limited amount of data, sufficient to answer a specific question. The findings of snapshot clinical audits may lead to a large-scale audit being undertaken. Operational staff, including Team Leaders, will be encouraged to undertake snapshot audits examining areas of care that may be of a specific concern in their local area.

8.2.3 Large-scale Clinical Audits

These clinical audits examine in detail patient care and adherence to guidelines across a larger area of the Service. With large-scale audits it is not unusual for data to be collected for a period of one year or more. These audits examine numerous aspects of care and can involve tracking patient outcomes and measuring patient satisfaction. These audits typically require third party collaboration (usually hospitals) and may need ethical approval. Large-scale audits will be led by the Clinical Audit Manager, under the supervision of the Head of Clinical Audit & Research, and incorporate a multidisciplinary audit working group to provide project direction, advice on methodology and findings, and contribute to report writing and developing recommendations. We will endeavour to involve in these working groups, as appropriate: LAS clinicians and other staff; representative from Clinical Education & Standards; specialist clinicians/advisors who work in the area of care being audited; patients/service users or representatives, and academic partners.

8.2.4 Clinical Performance Indicators

The LAS Clinical Performance Indicators (CPIs) are a quality improvement tool that enables the continual clinical audit of patient care as recorded on the Patient Report Form (PRF). CPIs are used to highlight good practice and areas of concern as well as assessing the quality of PRF documentation. CPI audits are undertaken by Team Leaders as part of their clinical supervisory role, enabling them to provide specific, constructive feedback to individual clinicians on areas of concern and offer praise for good practice. CARU monitors the CPI process, collates data and produces reports at a local (Group Station) and Service-wide level to benchmark Group Stations, draw attention to specific quality issues, and highlight improvements to practice.

8.2.5 Continuous Clinical Quality Monitoring

The LAS monitors the quality of care delivered to every patient who suffers a cardiac arrest, ST-elevation myocardial infarction (STEMI), stroke or major trauma; these patient groups make up the vast majority of our emergency calls. Using this type of audit activity, CARU produces local and Service-wide reports to benchmark Group Stations, highlight aspects of operational

performance and clinical care, inform future treatment options, and demonstrate the effectiveness of care packages specific to these patient groups.

8.2.6 Collaborative Clinical Audits

The LAS appreciates the importance of working collaboratively with other NHS Trusts and comparing our clinical care and performance with other ambulance services. As such, we will continue to develop and maintain partnerships, hold membership of regional and national clinical audit groups, and participate in national ambulance clinical audit initiatives. We will continue to assist with the verification of data for the Myocardial Ischemia National Audit Project (MINAP) and participate in National Confidential Enquiries and other national clinical audit projects as required.

9. Process for Ensuring Appropriate Standards of Performance are Audited

The objectives of each clinical audit project will be based on achieving best practice against set standards. Prior to commencing each clinical audit project, a literature scoping task will be undertaken to identify the latest evidence and guidelines on the topic area. Often the starting point will be the Clinical Practice Guidelines for Use in UK Ambulance Services. In addition, recent LAS operational and medical bulletins, and Clinical Updates, will be reviewed to capture all information that clinicians receive. The designated audit project lead, Clinical Audit Manager, and a qualified clinician (often a Clinical Advisor from the Medical Directorate) will design the audit standards in line with the objectives of the audit. A wider working group will be convened for larger-scale projects that may consist of both internal and external members (including patients and members of the public as appropriate) and will provide advice to CARU. CARSG will also be consulted as appropriate.

10. Collaborative Working

The LAS remains committed to a collaborative, multidisciplinary approach to both setting the clinical audit programme (via multidisciplinary membership of CARSG, see Section 7) and when undertaking clinical audit projects (via audit working group membership, see Section 8.2). In addition, we will endeavour to become involved in collaborative clinical audit activity whenever possible and appropriate (as described in section 8.2).

11. Patient and Public Involvement

Patients and members of the public will have input into the clinical audit process through numerous mechanisms. An audit may be triggered directly by patients highlighting a clinical quality concern in the form of complaints or enquiries. Patients may be actively involved in providing data for clinical audit projects where the methodology explicitly seeks patients' views and experiences of the quality of care. Patients' expertise is also used to guide the development of projects via involvement in multidisciplinary audit working groups, and to set the clinical audit programme via membership of CARSG.

12. Equality and Inclusion

We will endeavour to include within audit projects measures of equality and inclusion protected characteristics (including age, sex, ethnicity, pregnancy & maternity and disability) when these factors are known or expected to play a role in the presentation or treatment of conditions. The LAS will also, where possible, seek to take full account of equality and inclusion factors when conducting projects and reporting findings.

13. Data Protection

All clinical audits will be conducted in accordance with relevant legislation such as the Data Protection Act 1998, the 'Caldicott principles' (Caldicott Committee, 1997), Health and Social Care Act 2001, ethical guidelines, and National Information Governance Board regulations. All data collected will be: adequate; relevant; not excessive; accurate; processed for limited purposes; treated confidentially, and not kept for longer than necessary. Data will be held electronically and secured with encryption and password protection. Data access will be strictly limited to those directly working with it.

14. Format for Audit Reports

All clinical audit projects will be formally written up using a standard reporting structure which includes:

- Introduction
- Aims and objectives
- Methodology
- Results (including appropriate graphic representation)
- Discussion/Conclusion
- Recommendations (including re-audit dates and the sharing of outcomes/findings with other interested parties)
- Action plan (as appropriate)

Every clinical audit report will be reviewed and agreed by CARSG.

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15. Communication and Dissemination of Findings/Reports

The communication of audit findings to staff, patients, the public, and members of healthcare and scientific communities is a priority for the LAS. All clinical audit findings will be distributed to the Trust Board, the Executive Group, the Quality Oversight Group, the Clinical Effectiveness & Standards Group, CARSG and clinicians. Reports will also be shared externally with other ambulance services, A&E and other relevant hospital departments, academic partners, the LAS's Patients' Forum, and other relevant groups/organisations, as appropriate. We aim to disseminate reports within two weeks of CARSG and Medical Directorate sign-off, in line with the Dissemination Plan (see Appendices 5 & 6). The following methods, as appropriate, will be employed to ensure wide dissemination with advice being sought from the LAS's Communications department when necessary:

- Publish electronically on the internal Common Server
- Posters summarising the key findings and recommendations circulated to all stations
- Articles in the internal Clinical Update and/or Routine Information Bulletin, summarising the key findings and recommendations
- Publication of an Annual Clinical Audit Report citing the main findings and impacts of clinical audits undertaken during the year
- Electronic copies of the Annual Clinical Audit Report on the Intranet and the LAS website
- Presentation/posters at external conferences across the Service and at relevant external conferences
- Publication in relevant media (including peer-reviewed journals)

Operational staff will be able to influence the communication of findings through representation on CARSG and direct involvement in individual projects. Such staff involvement will help to ensure ownership of the findings and provide an effective means of spreading awareness of the clinical audit process.

16. Process for Making Improvements and Ensuring Action is Taken

When the findings from clinical audit identify a clinical quality issue or clinical need, the project lead, along with the clinical advisor and audit working group, will formulate recommendations to change practice. All recommendations will be presented to CARSG for approval and for advice on developing appropriate actions to lead to tangible changes to practice (see Appendix 6). An action plan will be developed for each recommendation to facilitate its implementation, and specific actions will be allocated to appropriate members of staff. Additionally, the

Medical Directorate and other relevant external stakeholders and groups (including the Clinical Effectiveness & Standards Group) may be consulted when setting recommendations that have a direct clinical impact.

The implementation of recommendations will be co-ordinated and overseen by the Clinical Audit Manager, with progress reported to CARSG, and monitoring undertaken by the Clinical Effectiveness & Standards Group. Where difficulties arise in the implementation of action plans these will be escalated to CARSG in the first instance, then to the Clinical Effectiveness & Standards Group and Quality Oversight Group, with further escalation to the Executive Group if required. The Clinical Audit Database will be utilised to facilitate and monitor this process.

17. Completing the Audit Cycle

In order to measure the impact of changes to practice, a subsequent audit (a re-audit) will be carried out to assess whether, and to what extent, the change has been adopted, and whether or not it has been effective. A re-audit will be undertaken where an initial audit has highlighted a clinical quality issue or area of concern, and a recommendation has been made to improve performance. Usually, re-audit projects will be undertaken a minimum of two years after the initial project, to allow sufficient time for changes to take place, although that can be undertaken sooner if appropriate. The principles that were applied to the initial audit will apply to any re-audit, although these projects may be scaled down to focus on the specific areas where the impact of change is expected.

18. Project Termination

To ensure that resources are not wasted and that data remains current, the LAS will employ the following rules for terminating projects that are no longer considered viable. We will consider stopping a project (with approval from CARSG) if any of the following criteria are met:

- The project exceeds its 'Best Before Date'. A project will be deemed to be 'out of date' when a period of one year has elapsed since the time at which the last data item was collected.
- There is a lack of data from collaborating parties. When partners fail to provide data in accordance with agreed deadlines, a 'two strikes' approach will be utilised through which a two-month grace period will be allowed, after which a further deadline will be negotiated, followed by escalation to their Medical Director or equivalent. Failure to meet the new deadline will either result in the project being terminated or, where possible, an alternative collaborator will be found, or the methodology will be revised so that collaboration is not necessary.
- Any instance where the audit lead fails to comply with the LAS's Clinical Audit Code of Practice or contravenes any regulations such as the Data Protection Act.

19. Evaluation of Clinical Audit Activity

“Effective clinical audit is about learning from our own and others’ failings, and using them positively as opportunities for improvement. It is fitting therefore that the same practices should be used in the practice of audit itself.”³

We will evaluate both the clinical audit programme and individual projects based on the criteria set out in the ‘Healthcare Quality Improvement Partnership: Best Practice in Clinical Audit’⁴ handbook. Project evaluation will involve key project participants who will assess whether or not the objectives were met and examine the quality improvements made. The Health Services Management Centre’s (HSMC) Clinical Audit Assessment Framework⁵ will be utilised to allow a more detailed review with ideas for improvement where appropriate. Lessons learned from the evaluations will feed into future audits and shape the overall clinical audit programme.

20. Cost Analysis

For all clinical audits, we will undertake a cost analyses to allow determination of the cost effectiveness of each project in relation to the recommendations that were produced and actions taken. This information will feed into the development of future clinical audit programmes and will prove useful for budget planning.

21. Access to Resources and Support for Clinical Audit

The LAS is committed to Continual Professional Development and, as such, we will provide appropriate support, training and supervision to all staff who contribute to clinical audit projects. We have developed a number of resources for staff, which includes: a code of practice; clinical audit handbooks; access to the Clinical Audit and Research Library containing books, peer-reviewed journals, copies of internal reports and reports produced by external organisations; an inter-library loans service; a journal article photocopying service, and internet access to free literature search engines (such as Medline). These resources are intended for use alongside structured support from CARU. We will also host quarterly ‘Evidence for Practice’ sessions and monthly advice ‘surgeries’ through which staff will be supported in developing their audit ideas and projects.

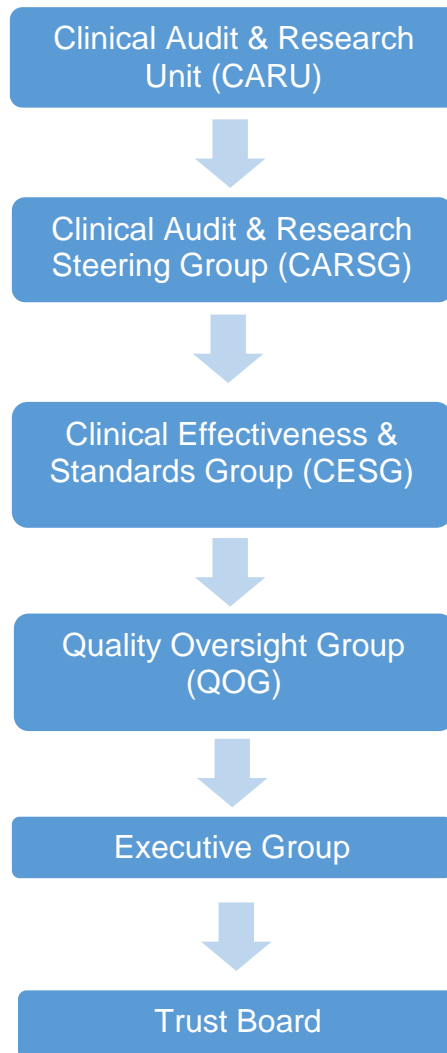
³ Walshe K.. Opportunities for improving the practice of clinical audit. *Quality in Health Care* (1995) 4: 231-2.

⁴ Healthcare Quality Improvement Partnership. (2016). *Best Practice in Clinical Audit*. London: Healthcare Quality Improvement Partnership.

⁵ Walshe K and Spurgeon P. (1997). *Clinical Audit Assessment Framework*. HSMC. Handbook Series 24, Health Services Management Centre, University of Birmingham.

IMPLEMENTATION PLAN				
Intended Audience	All LAS Staff, stakeholders, patients and wider public			
Dissemination	Available to all staff on the Pulse			
Communications	Revised Policy and Procedure to be announced in the RIB and a link provided to the document			
Training	CARU staff involved in clinical audit attend external, validated clinical audit courses. Team Leaders receive a one day internal clinical audit training programme. All LAS trained Paramedics attending the Academy receive training on the theory of clinical audit.			
Monitoring:				
Aspect to be monitored	Frequency of monitoring AND Tool used	Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported	Committee/ group responsible for monitoring outcomes/ recommendations	How learning will take place
Compliance with the principles and procedures including; <ul style="list-style-type: none"> - How the organisation sets priorities for audit, including local and national requirements - Requirements that audits are conducted in line with the approved process for audit - How audit reports are shared - Format for all audit reports (including methodology, discussion /conclusion, action plans, etc) - How the organisation makes improvements - How the organisation monitors action plans and carries out re-audits 	Bi-annual report of improvements made resulting from action plans/ recommendations, adherence to the dissemination plan for the sharing of clinical audit reports and findings (clinical audit database)	Clinical Audit and Research Unit reports to the Clinical Audit and Research Steering Group	Clinical Effectiveness & Standards Group	Learning disseminated via various mechanisms including Medical Directorate Bulletins, LAS News, Area Governance Meetings, etc
	Annual review of clinical audit working practices (including topic selection, use of the prioritisation tool, setting standards, the process of undertaking audits, setting recommendations and action plans, and disseminating findings and reports)	Self - nominated Inspector from the Clinical Audit and Research Steering Group reports back to the Clinical Audit and Research Steering Group		

The Position of Clinical Audit within the London Ambulance Service



The Clinical Audit and Research Steering Group Terms of Reference

1 Purpose

- 1.1 To provide oversight and monitoring of the planning and delivery of clinical audit and research activities in line with the Trust’s clinical and quality strategic objectives.
- 1.2 To provide to the Quality Oversight Group, via the Clinical Effectiveness and Standards Group (CESG), assurance on the delivery of the Trust’s clinical audit and research programmes in line with the Trust’s Clinical and Quality Strategies, and associated annual Quality Report.
- 1.3 To ensure there are robust arrangements in place for improving clinical outcomes and standards throughout the organisation by participation and acting on the findings from clinical audits and research programmes.
- 1.4 To oversee the objectives, planning and delivery of clinical audit and research within the Trust, in line with agreed annual programmes, providing expert advice and practical support where required.
- 1.5 Support compliance with the Care Quality Commission Regulations and Fundamental Standards.

2 Constitution

- 2.1 The Clinical Audit and Research Steering Group (CARSG) is established on the authority of the Quality Oversight Group.

3 Authority

- 3.1 CARSG is authorised by the Quality Oversight Group to investigate any activity and request appropriate assurance of compliance in line with its terms of reference.
- 3.2 It is also authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made.

4 Accountability

- 4.1 CARSG will report to the Quality Oversight Group via the CESG. The Quality Oversight Group in turn reports to the Executive Group. Any matters requiring Board approval under the Trust’s Scheme of Delegation and Reservation will be submitted to the Board via the Executive Group.

- 4.2 CARSG will provide regular briefings to the CESG on the progress of the annual clinical audit and research work programmes, and highlight any key clinical and quality issues it identifies, including non-compliance with the Care Quality Commission (CQC) Regulations and Fundamental Standards. This will be provided through quarterly Key Issues Reports and the minutes from each CARSG meeting.

5 **Chairperson**

- 5.1 The Chair of the Group will be the Medical Director
5.2 The Deputy Chair will be the Deputy Medical Director

6 **Membership**

6.1 **Internal:**

- Medical Director (Chair)
- Assistant Medical Director (Vice Chair)
- Chief Quality Officer
- Deputy Director of Quality and Nursing
- Deputy Director of Clinical Education and Standards
- Head of Clinical Audit & Research
- Assistant Head of Clinical Audit & Research
- Clinical Audit Manager
- Research Manager
- Quality Governance and Assurance Manager Representative
- Consultant Paramedic
- Advanced Paramedic Practitioner
- Senior Paramedic or Paramedic
- Clinical Team Leader
- Clinical Hub representative
- Emergency Ambulance Crew representative

6.2 **External**

- A patient representative
- Specialists in the following areas:
 - Emergency Medicine
 - Cardiac
 - Maternity
 - Toxicology
 - Stroke
 - Trauma
 - Geriatrics
 - Mental Health
 - Academic Research

7. **Expected Attendance**

- 7.1 There is a requirement for members to attend all meetings and a minimum 80%. If a deputy attends on behalf of a member they must have sufficient authority to make decisions on behalf of the group member.
- 7.2 Other specialists/attendees from other directorates may be requested to attend for specific purposes by invitation of the Chair.
- 7.3 Attendance will be recorded and reviewed by the group on an annual basis.

8. **Quorum**

- 8.1 The meeting will be quorate provided that the 50% of membership can attend which must include the Chair (or Deputy Chair) and the Head of Clinical Audit & Research (or nominated deputy).

9. **Frequency**

- 9.1 Meetings will be held bi-annually.
- 9.3 Midpoint Review Meetings between the Chair and members of the Clinical Audit & Research Unit will take place twice a year, between meetings, and minutes will be taken and distributed to the whole group.

10. **Key Responsibilities**

- 10.1. To oversee the objectives, planning and delivery of clinical audit and research activities within LAS, providing expert advice and practical support.
- 10.2 To approve the clinical audit and research programmes.
- 10.3 To review progress against objectives and targets.
- 10.4 To ensure that the LAS builds, maintains and effectively manages its clinical audit and research capacity and capability.
- 10.5 To provide expert peer review, as required, for research papers being submitted for publication.
- 10.6 To advise on the integration of new developments into clinical audit and research systems.
- 10.7 To provide regular reports on clinical audit and research activity and performance to CESG and to ensure the QOG is informed via the CESG of any exceptions to the achievement of the annual work plans and resulting risks, providing assurance as to how such risks will be mitigated and ensure that these are recorded on the relevant risk register(s) as appropriate.

- 10.8 To inform and contribute to the development of the Clinical and Quality Strategies and associated work programmes.
- 10.9. To contribute to providing assurance to the QOG that the Trust is compliant with the elements of the CQC 'Effective' domain within the group's remit.
- 10.10 To ensure that clinical audit and research findings are recognised by the LAS, acted upon and widely disseminated.
- 10.11 To provide assurance that processes for research permissions in the LAS are robust, timely and in accordance with national regulatory requirements.
- 10.12 To maintain a membership that is fit for purpose and capable of providing advice and knowledge corresponding to the needs of the group.

11 Process for monitoring compliance with Terms of Reference

- 11.1 Compliance will be monitored by reports on progress, regular agenda items covering the annual work plan for the Group and by producing Key Issues Reports to the CESG following each meeting.

12 Links to other meetings

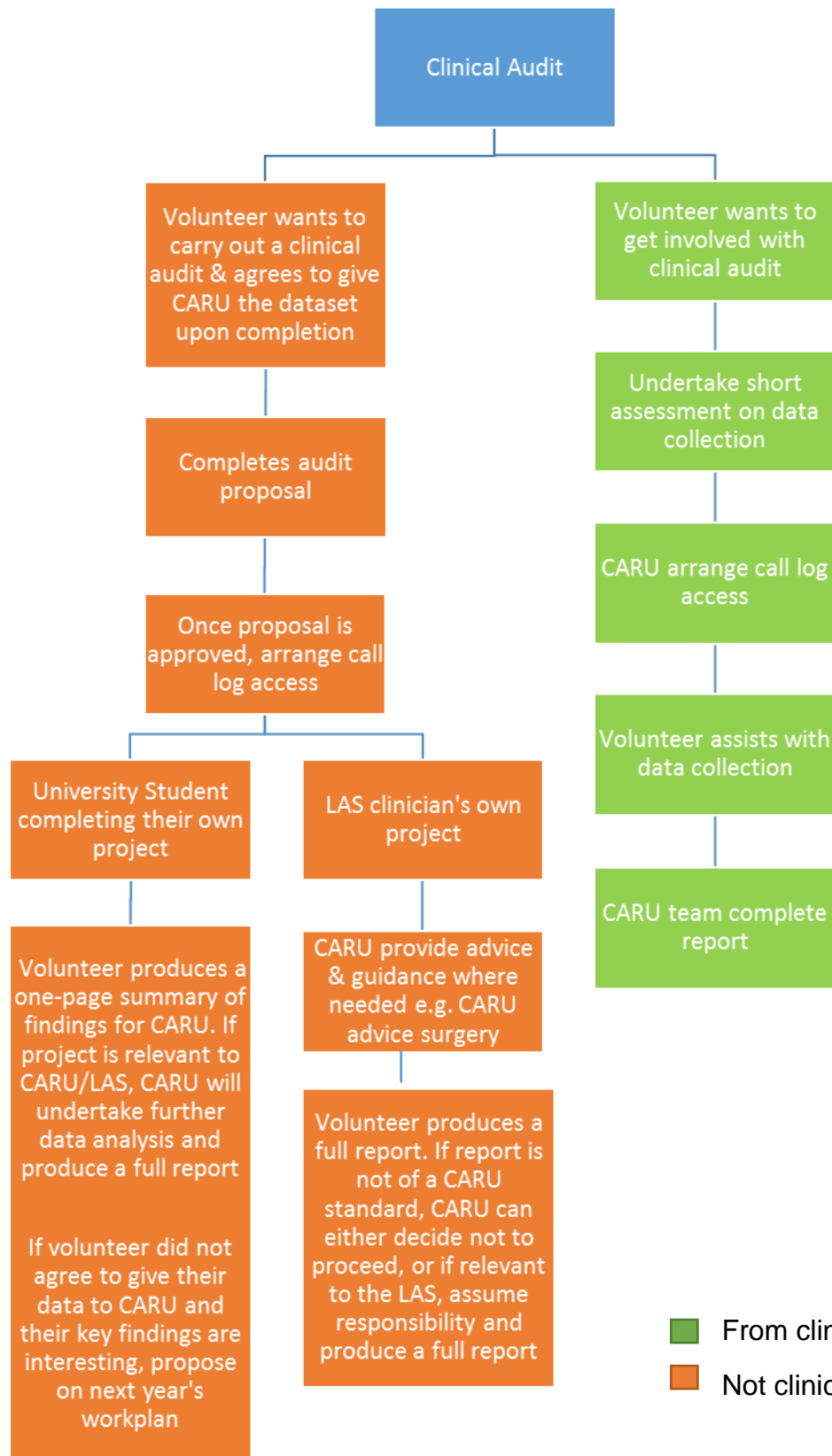
- 12.1 See 4.1 above

13 Review Date

- 13.1 These Terms of Reference will be reviewed annually by the Head of Clinical Audit & Research. They will be approved by CARSG and sent to CESG for information and ratification.

What will be monitored?	How/Method/Frequency	Lead	Reporting to	Deficiencies/gaps Recommendations and actions
Terms of Reference	Reviewed annually	Chair	CESG	Where gaps are recognised, action plans will be put into place; key issues will be escalated through CESG to QOG
Programme of work	Via Key Issues Report quarterly	Chair	CESG	Where gaps are recognised, action plans will be put into place; key issues will be escalated through CESG to QOG

Clinical Audit Volunteer Plan



- From clinical audit work plan
- Not clinical audit work plan

Trigger list for topic generation for clinical audit in the LAS

The following list outlines the triggers for areas that it would be of value to the LAS to audit. Decisions regarding which projects are included on the clinical audit work plan are made using the clinical audit selection and prioritisation tool.

- External requests and feedback from key stakeholders, including:
 - Department of Health
 - NHS England
 - National Institute for Health and Care Excellence (NICE)
 - Care Quality Commission (CQC)
 - Clinical Commissioning Groups
 - Trust Development Authority
 - Recommendations from Coroners
- LAS strategic objectives
- Complaints and feedback (from staff, other organisations, patients or the public)
- Outcomes from audits, re-audits and Clinical Performance Indicators (CPIs)
- New/revised clinical guidelines, including:
 - new drugs
 - new interventions
 - new clinical care pathways
- Patient safety incidents (clinical and non-clinical)
- Other risks, including:
 - administrative errors (e.g. coding errors)
 - incidents reported through risk management system (i.e. Datix, risk register).

LAS Clinical Audit Selection and Prioritisation Tool

The clinical audit selection and prioritisation tool has been developed to allow clinical audit ideas generated, through the use of the trigger list, to be prioritised in order of importance to the London Ambulance Service (LAS). The LAS has limited capacity to undertake clinical audit projects therefore the number of project selected for inclusion on the clinical audit work plan will depend on design of the highest priority projects.

The scoring template below lists criteria for clinical audit and allows for higher scoring for the ideas that will most benefit patients. Clinical audit ideas should be scored against each criterion as follows:

Score 0 if the criterion is not applicable

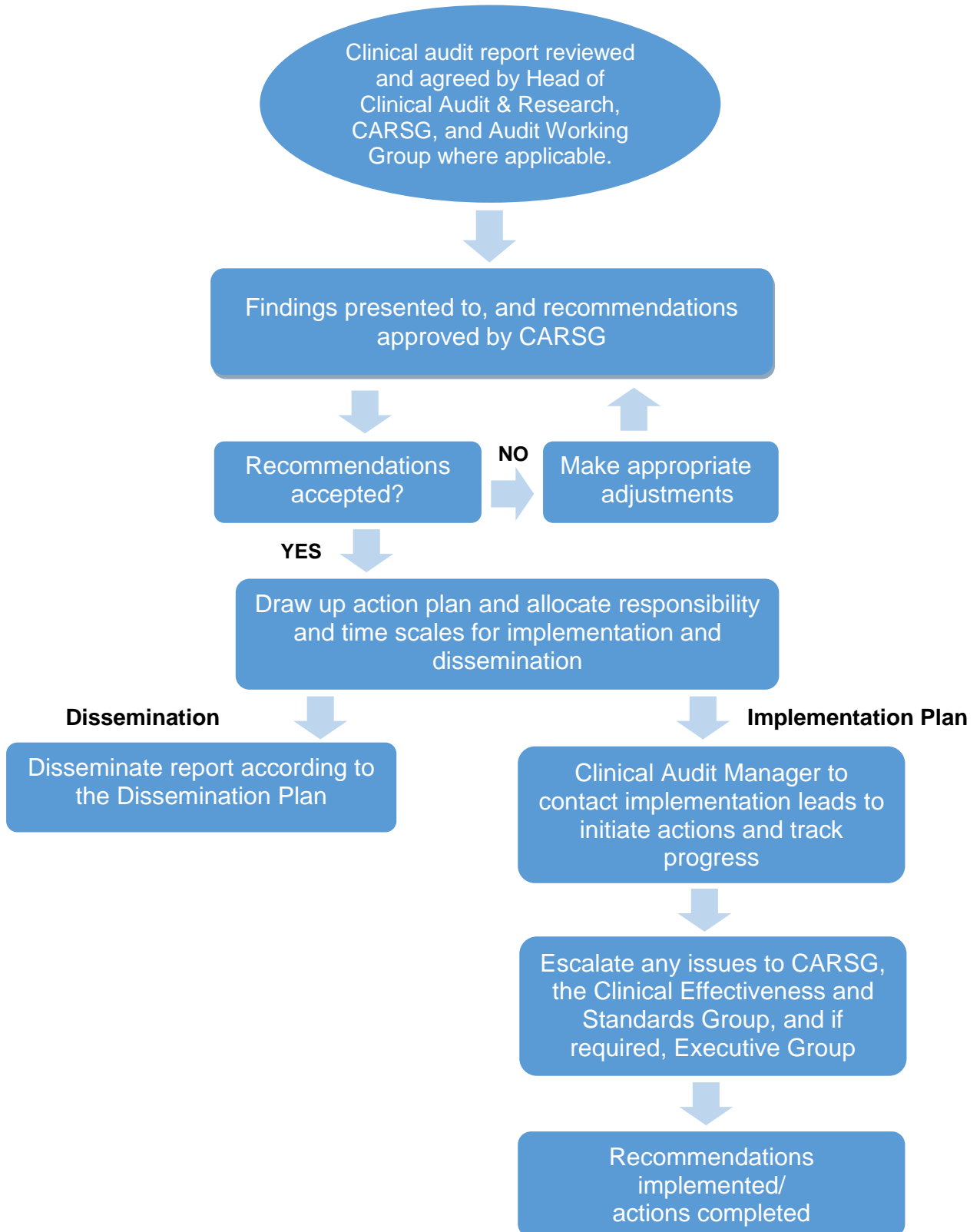
Score 1 if the criterion is applicable

Once every clinical audit idea has been scored, the projects will be ranked in terms of priority and the highest priority clinical audit projects selected for the clinical audit work plan for the upcoming year.

Scoring Template		
Criteria	Definition of Criteria	Scoring
Clinical quality issue	Is there evidence of a clinical quality issue? E.g. an acknowledged risk, complaint(s) or feedback (from staff, other organisations, patients or the public), serious incident(s).	x 5
Serious incident group review	Has the Serious Incident Group reviewed an incident related to this area? Have patient safety concerns been identified?	x 5
Recommendation from a baseline audit	Has a need for a more in depth clinical audit project been identified by a baseline audit or an ad-hoc clinical review?	x 4
Direct impact on patient outcome	Is there potential for impact on health outcomes for patients?	x 3
LAS strategic objectives	Is the area a strategic objectives or priority for the LAS?	x 3
External request	Is this an external request or feedback from a key stakeholder? E.g. DH, NHS England, NICE, CQC, CCGs, a Coroner.	x 3
Re-audit	Is this a re-audit where the initial clinical audit identified recommendations for improvement?	x 3
New or revised clinical guidelines	Is this in relation to a new or revised clinical guideline? E.g. new drug, intervention or clinical care pathway.	x 3
Cost	Is the delivery of care in this area expensive (and therefore diverting substantial funding away from other patients if used inappropriately)?	x 2
Funding availability	Is there a deadline associated with funding availability?	x 2
Collaborative audit	Is this a collaborative audit?	x 1
Volume	Is there potential to affect large numbers of patients?	x 1
Outcomes	Is outcome data available?	x 1
No potential for change	Is the problem amenable to change either internally, externally or nationally?	x -5

The LAS Clinical Audit Project Dissemination / Recommendations

Implementation Process



The Dissemination Plan

The following Dissemination Plan will be followed for dissemination of clinical audit findings and recommendations as appropriate for each project.

Internal

Distribution of full audit reports to:

Clinical Audit Working Group
 LAS Directors
 LAS Non-Executive Directors
 Quality Committee
 Clinical Effectiveness & Standards Group
 Clinical Audit and Research Steering Group
 Assistant Directors of Operations
 Each Ambulance Station
 Resource Centres
 Clinical and Quality Directorate
 Clinical Education and Standards (including Senior Management Team, Practice Learning Managers, Training Officers and Training Centres)
 Group Station Managers
 Quality Governance and Assurance Managers
 Operations Centre Managers
 Team Leaders
 Quality Assurance Unit.

External

Distribution of full audit reports to:

London A&E Consultants
 Medical Directors and Chief Executives of other UK ambulance services
 LAS Patients' Forum
 LAS Commissioners
 Relevant patient groups/organisations.

Other formats:

Posters for Ambulance Stations and Emergency Operations Centre (when appropriate)
 LAS Clinical Update and/or Routine Information Bulletin
 Inclusion in the Annual Clinical Audit Report
 LAS Intranet (The Pulse and the Common Server).
 Summarised in the Annual Clinical Audit Report on the LAS external website
 Presentation at external conferences (when relevant)
 Publication in peer reviewed scientific journals, magazines and popular journals (e.g. Health Service Journal; Ambulance U.K.) (when appropriate)

Clinical Audit Process

