Clinical Audit and Service Evaluation Policy and Procedure (N-046)

Version Number:	5.03
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Minor amendments made prior to full review date above (see appended document control sheet for details)	
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Date EMT as approving body notified for information:	*April 2024*

Policies should be accessed via the Trust intranet to ensure the current version is used

Contents

1 INTRODUCTION

Humber Teaching NHS Foundation Trust values the contribution of clinical audit in maintaining and providing assurance of high standards of patient care through regular review and evaluation of services.

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 (Best Practice in Clinical Audit; HQIP (Healthcare Quality Improvement Partnership), 2020).

The Trust has an ongoing cycle of clinical audit across the organisation, within both corporate and Service areas which include for example, national audits, POMH audits (prescribing observatory for mental health) pharmacy audits, review of practice against NICE guidelines. In addition to this there are audits around the Mental Health Act/Mental Capacity Act, safeguarding monitoring and reviews of practice following serious incidents and significant events to provide assurance of learning and quality improvement. The results of the clinical audits will provide assurance of compliance with clinical standards and best practice. Audit activity will also identify and seek to minimise risk, waste and inefficiencies within our services to improve the quality of care provided and improve patient outcomes.

Clinical audit is a statutory and contractual requirement for healthcare providers. The Care Quality Commission (CQC) also requires registered healthcare providers to regularly assess and monitor the quality of the services provided. It must use the findings from clinical and other audits, including those undertaken at a national level, and national service reviews to ensure that action is taken to protect people who use services from risks associated with unsafe care, treatment and support. Healthcare providers must also ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of the relevant professional bodies (for example, for revalidation).

Service evaluation uses systemic rigorous methods to describe and investigate the efficiency of an established service or clinical intervention with the purpose of generating information that is of local significance. The aim of service evaluation is to generate information that can be used to inform local decision-making (HQIP guide for clinical audit, research and service review; HQIP, 2011)

The Trust Board is required to certify that they have effective arrangements in place for the purpose of monitoring and continually improving the quality of healthcare provided to patients and must therefore ensure they have in place systems processes and procedures to monitor, audit and improve quality.

The purpose of this policy therefore is to set standards for clinical audit and service evaluation within the Trust, to clarify the roles and responsibilities of all staff engaged in clinical audit activities and to set out a framework which will allow the Trust to evidence assurance of best practice within services and meet external requirements.

2 SCOPE

This policy applies to anyone engaged in clinical audit and/or service evaluations under the auspices of the Trust and includes:

- all staff, clinical and non-clinical, including staff on short-term or honorary contracts, students and trainees in any discipline.
- patients, carers, volunteers, and members of the public

This policy also applies when clinical audit is undertaken jointly across organisational boundaries.

This policy also needs to be read in conjunction with the Trust Confidentiality Code of Conduct N-061.

3 POLICY STATEMENT

This policy provides a framework for the conduct of clinical audit and service evaluations undertaken within the Trust, with the aim of developing and sustaining a culture of best practice in clinical audit and service evaluation. This will include the Trust standards for:

- registering and approving clinical audit proposals
- developing and designing clinical audit/service evaluation tools
- reporting and presenting findings to the appropriate committee or clinical network for learning within the service areas and/or across the organisation
- providing assurance on standards of practice against best practice

The Trust is committed to supporting clinicians who carry out clinical audit by providing advice and guidance from appropriately trained and experienced clinical audit staff.

In addition, the Trust is committed to ensuring that:

- It participates in all national clinical audits, national confidential enquiries, inquiries and service reviews which are relevant to the services which it provides.
- All clinical audit activity within the Trust, or conducted in partnership with external bodies, is registered and conforms to nationally agreed best practice standards (Best Practice in Clinical Audit, HQIP 2016).
- The Trust programme of clinical audit activity meets the requirements of the Board Assurance Framework and includes all the clinical audits necessary to meet regulatory and commissioner requirements.
- Adequate records of the clinical audit programme, individual clinical audit projects and reviews of the results of national clinical audits, national confidential enquiries and inquiries and service reviews are maintained in order to demonstrate compliance with regulatory and other requirements.

For further details see: https://www.hqip.org.uk/resource/best-practice-in-clinical-audit/

The Trust encourages clinical audit is undertaken jointly across professions and across organisational boundaries. Partnership working with other local and regional organisations will be encouraged where improvements to the patient journey may be identified through shared clinical audit activity.

The Trust supports collaboration on multi-professional clinical audits of interest to other parts of the local health economy, both within and outside of the NHS, e.g. primary/secondary care, local authorities, independent health and social care providers etc.

The Trust promotes a commitment to the principle of involving patients/carers in the clinical audit process either indirectly through the use of patient surveys/questionnaires or directly through participation of identified individuals on project steering groups or patient forums.

4 DEFINITIONS

4.1. Clinical Audit

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

4.2. National Audits

National audits are organised by the National Clinical Audit and Patient Outcomes Programme (NCAPOP), are funded by the Department of Health and provide Trust's with feedback on the comparative findings to help identify improvements for people who use services locally. National audits are designed to improve patient outcomes across a wide range of medical, surgical and mental health conditions and their purpose is to engage all healthcare professionals in a systematic evaluation of their clinical practice against standards and to support and encourage improvement in the quality of care and treatment.

4.3. POMH – UK (Prescribing observatory for Mental Health)

POMH-UK is a national initiative to improve the quality of prescribing practice in mental health services through audit-based quality improvement programmes (QIPs). POMH-UK is based in the Centre for Quality Improvement at the Royal College of Psychiatrists. Audit data are collected by clinicians and clinical audit staff in participating Trusts and are submitted online. POMH analyse these data and provide benchmarked audit reports that allow Trusts and teams within these trusts to compare their prescribing practice with the audit standards and with each other.

4.4. Audit Criteria

Audit criteria are explicit statements defining an outcome to be measured and should be developed from the best available evidence.

4.5. Audit Standards

Audit standards:

- Are a measure of agreed performance/standards
- defines acceptable and unacceptable levels

It is important to provide clarity and definition in relation to the development and adoption of audit standards as these are used to benchmark current care against the best practice standards. Projects will only be recognised as clinical audit if relevant standards have been used to measure quality of care.

4.6. Re-audit

Re-audit involves repeating each stage of the clinical audit cycle and should be undertaken if the audit standard has not been met, however re-audit should not be undertaken routinely if the required standard has been achieved but agreed with the clinical care director/associate medical director within the relevant service area.

4.7. Service Evaluation

A service evaluation is a methodology used for the systematic assessment of a services aims, objectives, activities, outputs, outcomes and costs. Service evaluation does not require systematic comparison against a pre-determined standard but evaluates information to decide if a development or service is delivering the right outcomes and identify areas for improvement.

A service evaluation can use quantitative and/or qualitative data to explore strengths and weaknesses of services from a variety of perspectives including service user experience and cost benefit analysis. Service evaluation can stand alone as an individual project or may be used as a baseline for future audits/research or for benchmarking.

HQIP (2016) in their guide for clinical audit, research and service review identify the simple rules to identify the differences between clinical audit, research and service evaluation (https://www.hqip.org.uk/wp-content/uploads/2018/02/hqip-guide-for-clinical-audit-research-and-service-review.pdf). The clinical audit officer will review all proposals using the framework from this guidance to ensure proposals are correctly categorised.

5 DUTIES AND RESPONSIBILITIES

Trust Board and Integrated Audit and Governance Committee
The Trust Board is responsible via the Quality and Patient Safety (QPaS) Group for ensuring that the Trust has effective systems, processes and procedures in place to monitor, audit and improve quality.

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

Directors
The executive/board lead for clinical audit is the director of nursing, allied health and social care professionals. Their responsibilities in respect of clinical audit are:

- To ensure that the Trust clinical audit programme of work is allied to the Board's strategic interests and concerns.
- To ensure that clinical audit is used appropriately to support the Board Assurance Framework.
- To ensure (together with the medical director) that this policy is implemented across all clinical areas.
- To ensure that any serious concerns regarding the Trust's policy and practice in clinical audit, or regarding the results and outcomes of clinical audits, are brought to the attention of the Board.

Audit and Effectiveness Group (AEG)
The Audit and Effectiveness Group meets six-weekly with senior representation from across the 4 divisions and the corporate nursing team. AEG has oversight of all clinical audit activity which is tracked and monitored using the clinical audit module of InPhase. The divisions will provide assurance to AEG of compliance with clinical audit standards. Clinical audit activity will be reported through AEG to QPaS

Drugs and Therapeutics Group (DTG)
The Drugs and Therapeutics Group provides oversight of medicine related clinical audits and also reports to QPaS.

Clinical Network Groups (CNG)
The clinical network groups approve and oversee clinical audit projects and action plans within their service areas.

Together these groups are responsible for:

- Reviewing the audit proposals and audit criteria, standard and tools to support the clinical audit lead to deliver the clinical audit within the timescales agreed.
- Approval of proposed clinical audits (in order to reduce time delays, this role may be delegated to the chair of these groups).

- Ensure explicit consent is gained where it necessary under the terms of this policy (see Section 6).
- Authorise information leaflets and consent form where explicit consent is required.
- Authorise arrangements for gathering and anonymising retrospective information where implied consent is relied on.
- Monitoring the progress of clinical audits.
- Confirming the timescales for presentation of the report and findings to the agreed network/corporate group.
- Review of clinical audit reports, including:
    - Identification of improvement actions in response to clinical audit findings
    - Identification and empowerment/active support of lead clinicians to implement identified improvement actions
    - Monitoring progress of improvement actions in the form of action plans
    - Signing off of completed improvement action plans as appropriate
    - Recommending priorities for re-audit

Corporate support
The clinical audit and practice development team is responsible for:

- Maintaining the Trusts' clinical audit programme of work.
- Providing oversight and support to the clinical audit governance processes of proposal, prioritisation, approval, monitoring and completion of all clinical audits carried out within the Trust.
- Providing support as requested to support clinical networks and practitioners to undertake clinical audit.
- Supporting clinical networks in the monitoring of progress for clinical audits via InPhase and providing support and escalation where needed.
- Supporting clinical networks in the monitoring of progress for clinical audit action plans carried out within the Trust, and continually liaising with responsible clinicians to ensure timely completion of these action plans.
- Dissemination of audit reports to the AEG, DTG, Mental Health Legislation Committee, QPaS, clinical network groups and lead clinicians as appropriate.
- Maintaining InPhase database to manage the clinical audit workflow and achieve the duties described above.
- Review of all reports prior to submission to the clinical networks or AEG for review.

Clinical Networks
The clinical network groups are responsible for:

- Ensuring that service development and delivery is underpinned by clinical audit and forms part of continuing professional development.
- Ensuring the staff they manage adhere to this policy.
- Ensuring that all clinical audit activity within their jurisdiction is registered and complies with nationally accepted best practice standards.
- To review and agree all local clinical audit proposals and service evaluation proposals.
- Ensuring staff within their sphere of responsibility participate in all national clinical audits, national confidential enquiries, service reviews and other audits agreed within the clinical networks.
- Working with clinicians and clinical audit staff to ensure that the clinical audit activity for their area of responsibility meets all clinical, statutory, regulatory, commissioning and other Trust requirements.
- Support the implementation of service changes that may result from the findings of clinical audits.
- Review and monitor all action arising from clinical audit activity.

Professional and Clinical Leads
The professional and clinical leads are responsible for ensuring that standards from their professional registering bodies, e.g. for record keeping, are included in any relevant Trust audits.

Clinical Staff
Clinical staff have a responsibility for the quality of the service which they provide, and all clinically qualified staff are individually accountable for ensuring they audit their own practice in accordance with their professional codes of conduct and in line with the standards set out within this document.

In addition, all clinical staff are responsible for:

- Complying with the directions and procedures relating to the management and completion of clinical audit projects as outlined within the clinical audit plan agreed within the Trust.
- Not undertaking **any** clinical audit and or service evaluation activity without informing, involving and following the direction of the corporate clinical audit staff.

6 AUDIT PROCEDURE

Priority Setting in Clinical Audit
Each Division will undertake a minimum of 5 clinical audits per financial year to meet the Trust's corporate requirements for assurance, CQC requirements, statutory and contractual requirements.

All current and proposed clinical audit activity being undertaken will be recorded within InPhase. The database will confirm the lead clinical network, the lead auditor, date of initial agreement to undertake audit and review date.

Priorities for each division's audit activity and service evaluation will be derived from the following:

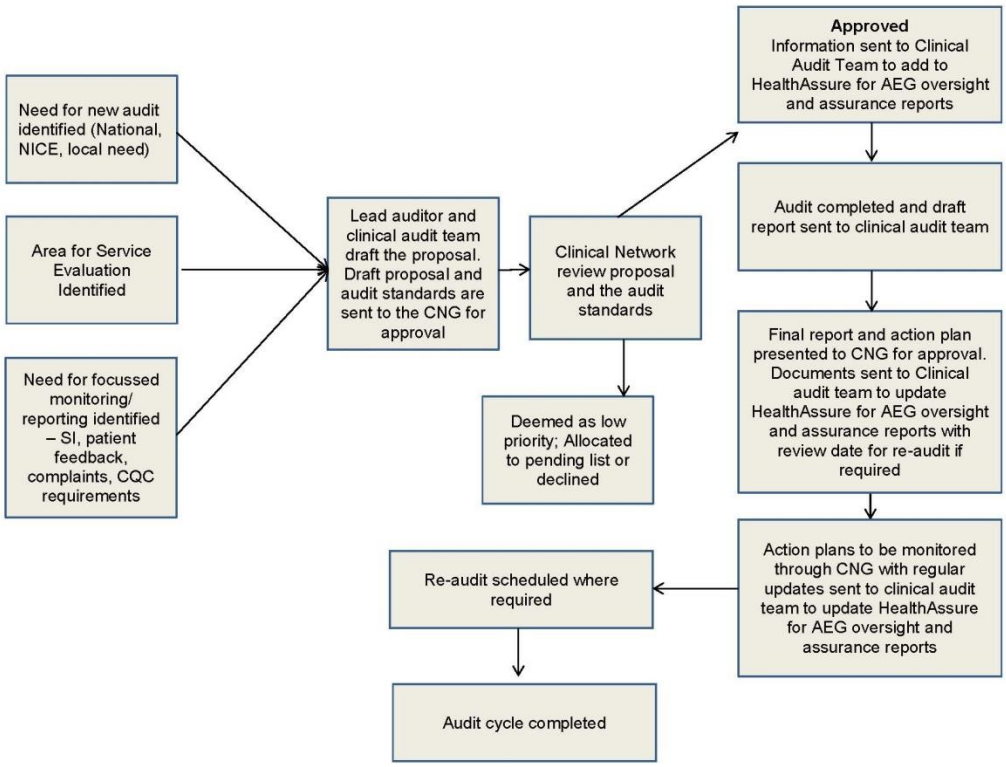
- National Confidential Enquiries, National Clinical Audit and Patient Outcomes Programme or other national programmes.
- Review of NICE Guidance/Quality Standards and compliance with same.
- Prescribing Observatory for Mental Health (POMH-UK).
- Findings from Serious Incidents or Significant Events as identified by the Clinical Risk Management Group (CRMG).

Corporate Services and divisions working with and alongside clinical network groups will prioritise proposed clinical audits in line with these priorities and will provide evidence that services and interventions are assessed against best practice, thereby providing assurance and compliance to national and/or local standards.

Developing an audit proposal
Proposals for clinical audit will be developed by the lead auditor in collaboration with the Clinical audit and practice development team. Proposal forms can be obtained by contacting the clinical audit facilitator by emailing HNF-TR.ClinicalAudit@nhs.net. Upon completion the draft proposal will be forwarded to the clinical networks. The submission of the clinical audit proposal form to the clinical network must be accompanied with the standards by which the clinical audit is measuring against. Only proposals that have been reviewed and approved through the relevant clinical network will be entered onto the clinical audit plan.

With the exception of national audits and POMH audits, all proposed audits must be formally approved by the relevant corporate, service or clinical network before commencement. All service areas must support national audits and POMH audits through the identification of lead professionals and staff to implement and oversee the audit.

Full process map of requirements for audit



National Audits

- National audits will be entered on InPhase and marked pending.
- Optional national audits will be reviewed by the deputy director of nursing. If deemed not a priority or not for inclusion on the audit work plan a relevant statement will be recorded on InPhase.
- If audit is mandated or identified for inclusion, it will be sent to clinical network leads for allocation or discussion at clinical network meeting.
- If deemed applicable the clinical audit facilitator will update InPhase with the clinician allocated as audit lead. If the allocated clinician is not an existing InPhase user, the clinician will need to complete a Portal Access Request Form (available from Trust intranet)
- If a HQIP national audit then details of the national project manager will be sent to the allocated audit lead. The lead will register with the national body and cc the Trust clinical audit officer in all communications. The audit lead will submit audit data on national dashboard. Monthly progress reports and quarterly position statements will be provided to AEG via the clinical audit facilitator and uploaded to InPhase. On completion the audit lead will update the national project manager and InPhase. When the national report is published the clinical audit officer will upload to HealthAssure and submit to the relevant clinical network(s). The clinical network(s) will agree any priority/actions, update the plan on InPhase and inform AEG of any further work required. The clinical audit officer will update InPhase RAG rating, record on integrated performance tracker dashboard and disseminate to other applicable clinical network(s). Actions are to be completed in a specified timeframe. Any outstanding issues to be escalated to QPaS and sent back to clinical network(s) by the clinical audit officer. AEG to review progress and note final position.
- If not a HQIP national audit the clinical audit facilitator will email the InPhase link to the allocated audit lead. If applicable to more than one clinical network a lead will be agreed by AEG. A gap analysis will be carried out by the relevant clinical networks(s) or allocated audit lead. They will assess the current level of compliance, assign and agree any actions identified. The allocated audit lead or clinical network will provide monthly progress reports ~~to~~ via audit reports in InPhase and AEG. Identified actions or information will be disseminated to relevant clinical network(s) by audit lead. The clinical audit officer will

update InPhase and record on the integrated performance tracker dashboard. Actions to be completed in specified timeframe. Any outstanding issues to be escalated to QPaS and sent back to clinical network(s) by the clinical audit officer. AEG to review progress and note final position.

Local Audits

- Local clinical audits will be scrutinised by the clinical network(s) to assure relevance to Network and methodological quality.
- Once the clinical audit has been approved by the clinical network, they will inform the clinical audit facilitator who will register the audit on InPhase The audit lead will provide a monthly progress report to their clinical network and clinical audit facilitator. The clinical audit facilitator will update InPhase and disseminate information to other applicable clinical network(s). Actions to be completed in specified timeframe and monitored via InPhase. Any outstanding issues to be escalated to QPaS and sent back to clinical network(s) by clinical audit facilitator. AEG will review progress and note final position.

POMH

POMH-UK audits will be monitored by the Drugs and Therapeutics Group which reports to QPaS.

Writing the clinical audit report and action plan

Once the audit is completed, the clinical audit lead must produce a report and action plan using the Trust clinical audit report template which will be sent to the lead auditor by the clinical audit facilitator upon commencement of the audit project. Action plans should be specific, measurable and achievable/realistic and have clear implementation timescales with identified leads for each action. This is not necessary when undertaking POMH or national audits, as reports are produced nationally.

Sharing the findings

An electronic copy of the report and action plan must be sent to the clinical network for review and sign off. Copies of completed reports should also be shared with AEG or in the case of drug related audits the Drugs and Therapeutic Group. All approved audit reports will be published on the clinical audit page of the Trust Intranet. Clinical networks should identify if there is a need for re-audit and timescales.

Monitoring of action plans

Clinical network(s) will monitor the implementation of actions plans. Clinical networks will confirm if re-audit is required and agree timescales for the re-audit or if assurance has been achieved of the standards. The reports of any re-audits will contain a clear comparative section to indicate levels of change in standards as well as current compliance with standards. Medicines-related audits will be reviewed by the Drugs and Therapeutic Group who will recommend if re-audits following the implementation of an action plan to achieve the quality improvement.

Information Governance

Clinical audits which do not require explicit patient consent: Where it is possible to carry out a study without using or accessing confidential identifiable client data at any stage, then there is generally no need to obtain explicit consent. Therefore, the development in the use of privacy-enhancing technology within the Trust is to be encouraged.

Where it is still necessary for identifiable information to be used or accessed it may still be possible to proceed without obtaining explicit consent. The use of patient data for the provision of care and clinical audit are effectively conditions of receiving treatment. The acceptance of treatment by the patient will imply consent to these uses or disclosures, providing that:

- The patient has received the Trust leaflet “Your information – Our key to your best health care” about how their information is used and no objections have been raised. Any objections are recorded as an alert/reminder on the manual and electronic record

and

- The information is retrospective using healthcare records, does not involve or affect clients directly, and will be gathered and anonymised by a member of the healthcare team or where this is not practical by a member of the clinical audit department or in exceptional circumstances other individuals expressly authorised by the Caldicott Guardian and the approving service area/clinical network/AEG/Drugs and Therapeutics Group.

Clinical audits which require patient explicit consent:

Explicit consent is required:

- If there is a possibility that an individual will be affected by any aspect of the project, including personal involvement, subsequent contact, or feedback of information.
- If it is practical to approach potential subjects to obtain their explicit consent.
- Where personal information may be disclosed to a third party organisation.

The most frequent types of audit work that require explicit consent are patient questionnaires and observed practice.

Where consent is required, it is the responsibility of the project lead to provide the client with an information leaflet that identifies:

- The identity of the Trust as the data controller and the initial recipient of the information.
- To which organisations this personal data may be disclosed.
- The purpose and methodology of the project, including a basic explanation of what information is involved and a description of the benefits that may result from the project.
- How any information disclosed to the Trust will be used including the guarantee that the results will be presented anonymously.
- How the information will be protected and assured, including how long the information is likely to be retained, and under what circumstances it will be destroyed.
- The identities of participating organisations.
- Contacts for raising queries regarding the project.
- Contacts for raising queries relating to data protection or confidentiality within the Trust.
- That there is no obligation to participate, and that declining will have no adverse effect on their treatment.

The information provided must allow for disabilities, illiteracy, diverse cultural conditions and language differences.

The patient consent form must include the title and reference of the project, name of the project lead and a reference to the information leaflet. The consent forms should be retained and filed with the medical record when the project is complete. The consent is only valid for the project specified in the consent form.

A copy of the proposed patient information leaflet and consent form should be submitted with the project proposal for projects requiring explicit consent.

When seeking explicit consent from the patient, the project lead must ensure that patients are provided with:

- Honest, clear, objective information about information uses and their choices – this information may be multi-layered, allowing patients to seek as much detail as they require.
- An opportunity for patients to talk to someone they can trust and of whom they can ask questions.
- Reasonable time (and privacy) to reach decisions.
- Support and explanations about any form that they may be required to sign.

- A choice as to whether to be contacted in the future about further uses, and how such contact should be made.

Safeguarding confidentiality
All staff undertaking clinical audits must comply with the following standards to safeguard client confidentiality.

- Collect the minimum necessary patient identifiable information to achieve the aims and objectives of the clinical audit project.
- Anonymise or pseudonymise data as early in the project as possible.
- Take appropriate security measures to keep client information physically and electronically secure and available only to those who need to know. The Trust's Safe Haven Policy, Information Security Policy and User Responsibilities for Passwords must be followed.
- Do not take patient identifiable information outside Trust premises.
- Retain all patient identifiable data until the final report has been distributed. All identifiable data should then be shredded or deleted.
- Do not identify individual clients in an audit report or in any presentation of findings.

The project lead, who must be a substantive employee of this Trust, becomes the 'data owner' for all file sets of personal data relating to their project and it is their responsibility to ensure compliance with these standards. All project leads must be a substantive employee of the Trust.

An exception to this is where the clinical audit department is responsible for the collection and processing of the client identifiable data, in which case the clinical audit data owner will retain responsibility for all file sets and ensure compliance with these standards.

Use of non-healthcare team to collect and input confidential patient data
Ideally access to client data should be restricted in the first instance to members of the healthcare team delivering the care. However, where this is not possible it is permissible for someone outside the team who is suitably trained and subject to a duty of confidence to collect the data from the records and make it anonymous without seeking patient consent.

All staff outside the healthcare team who collect and process confidential client data for clinical audit purposes must:

- Have a substantive contract with the Trust that makes them subject to a duty of confidence.
- Have undertaken information governance training and be aware of their duty of confidence in relation to disclosure of patient identifiable data.
- Have completed a confidentiality agreement from the code of conduct for employees in respect of confidentiality and information security.

Ideally this should be restricted to members of the clinical audit department. In exceptional circumstances, staff from other departments; a clinical secondee with an honorary contract; or an employee of a partner organisation; may be asked to participate in this data collection. They can only be involved with the explicit approval of the Caldicott Guardian or senior information risk owner and the approving clinical networks/clinical audit officer or Drugs and Therapeutics Group.

These persons must:

- Have a contract of employment with the Trust (either substantive or honorary) and be subject to Trust standards checks, including DBS.
- Have a schedule of instruction defining the parameters of the Trust approved research.
- Identify and exclude patients who have raised an objection. Objections will be logged as an alert/reminder on the electronic and manual record.
- Not have any business/employment relation with any commercial organisation who may be benefit from the research and sign a declaration of interests.
- Be supervised by the team leader.
- Have undertaken information governance training.

The project lead must discuss these exceptional circumstances with the clinical audit department who will ensure that approval is sought where required.

It should be noted that anyone on an honorary contract cannot be the project lead. The issue of an honorary contract to an individual in order to enable them to undertake an audit will be restricted and only allowed where the honorary employee can be closely supervised by a substantive senior member of the Trust. Unless the audit is a national priority then the impetus for the audit and the benefit of undertaking the audit should lie with the Trust and not an external individual or organisations.

Clinical audit involving third parties
Section 251 NHS Act 2006 allows essential identifiable information to be shared with outside agencies without consent, in tightly controlled circumstances. The Health Research Authority provides Section 251 for projects. All such potential disclosures should be referred to the Caldicott Guardian for authorisation.

Section 251 approval is not required for local cross-boundary clinical audit providing that:

- the audit is conducted by one of the partner organisations that has delivered the patient's care or treatment
- the audit is carried out in accordance with clinical governance guideline
- it has been approved by the medical director and Caldicott Guardian for the trust in question

7 SERVICE EVALUATIONS

Service evaluation proposals should be completed by the project lead in conjunction with the clinical audit and practice development team. Service evaluation forms can be obtained by contacting the clinical audit facilitator by emailing HNF-TR.ClinicalAudit@nhs.net. All service evaluation proposals must be approved by the relevant clinical network group.

Review checks:

- Is this a service evaluation project?
- Process is in place for contacting potential participants/consent (as appropriate).
- Suitable accompanying documents (participant information sheet/consent form).
- Ethics (risk assessment/information governance).
- If project deemed high risk or considered to be research rather than service evaluation; the corporate team will refer to lead for research for advice.
- Is the sample appropriate?
- Is there agreement of key stakeholders in place?

Service evaluation proposals and project will be incorporated into InPhase and will be monitored via the clinical networks with oversight from AEG in the same way as clinical audit.

A draft report on the service evaluation should be received by the clinical network at the date identified within the proposal form. The report is completed using the brief audit report template which will be sent to the project lead by the clinical audit facilitator when the proposal has been approved by the clinical network. The final report will be circulated to the clinical network and AEG for review.

8 TRAINING

Clinical audit information and advice is available on the Trust intranet or from the clinical audit and practice development team by emailing HNF-TR.ClinicalAudit@nhs.net. In addition, appropriate educational resources on clinical audit processes are available through the HQIP website www.hqip.org.uk.

The Trust is committed to supporting clinicians who carry out clinical audit by providing advice and guidance from appropriately trained and experienced clinical audit staff. Appropriate training is available to all staff via the links on the Trust intranet to the Health Quality Partnership (HQIP) and the Clinical Audit Support Centre (CASC).

9 EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA.

10 IMPLEMENTATION

This policy will be disseminated by the method described in the Document Control Policy.

11 REFERENCES / EVIDENCE

HQIP (2011) A Guide for Clinical Audit and Service Review – an educational toolkit designed to help staff differentiate between clinical audit, research and service review activities. Healthcare Quality Improvement Partnership: London.

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

Clinical Audit	The evaluation of clinical performance against standards or through comparative analysis, with the aim of informing the management of services.
Confidential Client Information	Data which relates to a living or deceased individual who can be identified or distinguished from others.
Anonymised Data/Information	Data from which individuals cannot be identified by any recipient of the information. Anonymisation requires the removal of name, address, full post code and any other detail or combination of details that might support identification.
Pseudonymised Data/Information	Data that can be traced back to an individual but only by those who have the 'decode'.
Processing	Obtaining, recording or holding the information or data or carrying out any operation or set of operations on the information or data including retrieval, consultation or use of the information or data.
Partner organisation	Organisations that have signed the Humber Information Sharing Charter.
Caldicott Guardian	An officer within the Trust responsible for agreeing and reviewing internal protocols governing the protection and use of patient identifiable information, governing the disclosure of patient information across organisational boundaries, and resolving any local issues arising from the above.

12 RELEVANT TRUST POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

NICE Implementation Policy

Confidentiality Code of Conduct

Appendix 1: Document Control Sheet

This document control sheet must be completed in full to provide assurance to the approving committee.

Document Type	Clinical Audit and Service Evaluation Policy and Procedure (N-046)		
Document Purpose	This policy provides a framework for the conduct of clinical audit and service evaluations undertaken within the Trust, with the aim of developing and sustaining a culture of best practice in clinical audit and service evaluation. This will include the Trust standards for: • registering and approving clinical audit proposals • developing and designing clinical audit/service evaluation tools • reporting and presenting findings to the appropriate committee or clinical network for learning within the service areas and/or across the organisation • providing assurance on standards of practice against best practice		
Consultation/Peer Review:	Date:	Group/Individual	
List in right hand columns consultation groups and dates	April 2021	Tracy Flanagan	
	April 2021	Haley Jackson	
	4th April 2024	QPaS	
Approving Committee:	Quality and Patient Safety Group	Date of Approval:	04 April 2024
Ratified at:	N/A	Date of Ratification:	
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*		Financial Resource Impact	
Equality Impact Assessment undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	InPhase [✓]	
Implementation:	*Describe implementation plans below – to be delivered by the author:*		
	This policy will be disseminated by the method described in the Document Control Policy.		
Monitoring and Compliance:			

Document Change History: (please copy from the current version of the document and update with the changes from your latest version)			
Version number/name of procedural document this supersedes	*Type of change, e.g. review/legislation*	*Date*	*Details of change and approving group or executive lead (if done outside of the formal revision process)*
2.00	*Review*	*14/1/11*	
2.01	*Review*	*3/10/11*	*Reviewed no major changes*
3.00	*Review*	*20/8/12*	*Major amendments made to reflect corporate changes, meet NHSLA standards and bring into line with HQIP guidance*
4.00	*Review*	*04/04/16*	*April 16 Changes to process and structures* *Nov 16 – update to process and structures*
4.01	*Review*	*08/03/2017*	*Information Governance elements incorporated into the policy.*
5.00	*Review*	*14/12/2018*	*Major review to incorporate new process*
5.01	*Review*	*11/11/2020*	*Minor changes to align with new structures and processes as per the recommendations of the internal auditors. Removal of the proposal form and clinical audit report template from the main policy document.*
5.02	*Review*	*25/03/24*	*Full review however only minor changes to add new authors. Removal of HealthAssure and addition of new system InPhase.* *Approved at QPaS 4th April 2024*

Appendix 2: Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: Clinical Audit and Service Evaluation Policy and Procedure N-046
2. EIA Reviewer (name, job title, base and contact details): Kate Baxendale, Deputy Director of Nursing, Allied Health Professionals and Social Work Professionals kate.baxendale@nhs.net Andre Grell, Clinical Audit Facilitator, andre.grell@nhs.net
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Policy and procedure

Main Aims of the Document, Process or Service
The purpose of this policy therefore is to set standards for clinical audit and service evaluation within the Trust, to clarify the roles and responsibilities of all staff engaged in clinical audit activities and to set out a framework which will allow the Trust to evidence assurance of best practice within services and meet external requirements.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	This is a non-clinical policy and related to the development of clinical audit and service evaluations occurring as outlined within the clinical audit plan
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental Health (including cancer, HIV, multiple sclerosis)	Low	This is a non-clinical policy and related to the development of clinical audit and service evaluations occurring as outlined within the clinical audit plan
Sex	Men/Male Women/Female	Low	This is a non-clinical policy and related to the development of clinical audit and service evaluations occurring as outlined within the clinical audit plan
Marriage/Civil Partnership		Low	This is a non-clinical policy and related to the development of clinical audit and service evaluations occurring as outlined within the clinical audit plan
Pregnancy/ Maternity		Low	This is a non-clinical policy and related to the development of clinical audit and service evaluations occurring as outlined within the clinical audit plan
Race	Colour Nationality Ethnic/national origins	Low	This is a non-clinical policy and related to the development of clinical audit and service evaluations occurring as outlined within the clinical audit plan

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Religion or Belief	All Religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	This is a non-clinical policy and related to the development of clinical audit and service evaluations occurring as outlined within the clinical audit plan
Sexual Orientation	Lesbian Gay men Bisexual	Low	This is a non-clinical policy and related to the development of clinical audit and service evaluations occurring as outlined within the clinical audit plan
Gender reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	This is a non-clinical policy and related to the development of clinical audit and service evaluations occurring as outlined within the clinical audit plan

Summary

Please describe the main points/actions arising from your assessment that supports your decision. This is a non-clinical policy and is restricted to clinical audit and service evaluations occurring as outlined within the clinical audit plan.	
EIA Reviewer: **Kate Baxendale (Deputy Director of Nursing) / Andre Grell (Clinical Audit Facilitator)**	
Date completed: **25 March 2024**	Signature: **K Baxendale / A Grell**