**Quality Assurance and Clinical Audit Policy**

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| **Version:** | **Review date:** | **Edited by:** | **Approved by:** | **Comments:** |
| v1.2 | 16/06/2022 | Sultan Mohamed | Munira Mohamed | Adapted from PI template 1.2 |
| v1.3 | 09/03/2024 | Sultan Mohamed | Munira Mohamed |  |
|  | June 2026 |  |  | Next review |
|  |  |  |  |  |

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# Introduction

## Policy statement

In order for Sheerwater Health Centre to meet the requirements of the [Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17](http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-17-good-governance#guidance), there must be demonstrable evidence of quality assurance. This includes effective governance, assurance and auditing processes that are aimed at improving the quality-of-service delivery and to ensure conformity to achieve a common high standard.

This organisation puts the needs of our patients first whilst embracing a culture of transparency, openness and learning. These principles and values are outlined within the [NHS Constitution for England](https://www.gov.uk/government/publications/the-nhs-constitution-for-england) and this policy underlines our commitment to quality improvement.

The CQC advises that practices should routinely review the effectiveness and appropriateness of the care provided to provide effective, safe care and this policy should be read in conjunction with the following GP Mythbusters:

* [GP Mythbuster 4: Quality improvement activity](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-4-quality-improvement-activity)
* [GP Mythbuster 64: Effective governance arrangements in GP practices](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-64-effective-governance-arrangements-gp-practices)
* [GP Mythbuster 65: Effective clinical governance arrangements in GP practices](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-65-effective-clinical-governance-arrangements-gp-practices)
* [GP Mythbuster 70: Mandatory training considerations in general practices](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-70-mandatory-training-considerations-general-practice)

Further reading regarding quality, audit and other types of clinical governance can also be found within:

* **The Governance Handbook**
* **Management Policies and Procedures**

## Status

The organisation aims to design and implement policies and procedures that meet the diverse needs of our service and workforce, ensuring that none are placed at a disadvantage over others, in accordance with the [Equality Act 2010](https://www.legislation.gov.uk/ukpga/2010/15/contents). Consideration has been given to the impact this policy might have regarding the individual protected characteristics of those to whom it applies.

This document and any procedures contained within it are non-contractual and may be modified or withdrawn at any time. For the avoidance of doubt, it does not form part of your contract of employment. Furthermore, this document applies to all employees of the organisation and other individuals performing functions in relation to the organisation such as agency workers, locums and contractors.

# Clinical audit

## Overview

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

Regular audits are to be undertaken with the overall aim being to ensure that the organisation is meeting the standards required, while reviewing processes to identify areas for improvement as necessary. The purpose of completing a clinical audit is to enable staff to review their own practise and that of their colleagues with an overall aim of making improvements to benefit the service user.

A clinical audit will:

* Identify and highlight evidence-based practice
* Identify areas for improvement and enhance patient safety
* Provide data that can be used to review the effectiveness of service delivery
* Enhance multidisciplinary team communication
* Improve cross-functional working within the organisation

The features of a clinical audit as detailed by [Healthcare Quality Improvement Partnership](https://www.good-governance.org.uk/wp-content/uploads/2017/04/clinical-audit-a-simple-guide-for-nhs-boards-and-partners.pdf) (HQIP) are that it:

* Is a circular process system by which clinicians review their own clinical practice but which can be used throughout the organisation to review effectiveness
* Has a quality improvement intent
* Is systematic
* Is undertaken with the active involvement of those directly involved in the care process
* Looks beyond the immediate care process and may encompass resources devoted to a particular care pathway
* Considers processes allied to the direct pathway of care, such as the initial selection of patients for the care pathway concerned
* Uses established and agreed standards which are in themselves a means to ensure good quality care leading to better outcomes
* Compares actual practice to these standards
* Confirms compliance with standards or that necessary remedial action is taken
* Remeasures to gauge improvement

All staff participate in the audit process which also promotes reflective practice and individual learning. Ultimately, clinical audits enable the team to assess clinical performance and improve clinical practice while enhancing the care delivered to our patient population.

Further guidance can be sought within the NICE document titled [Principles for Best Practice in Clinical Audit](https://www.nice.org.uk/media/default/About/what-we-do/Into-practice/principles-for-best-practice-in-clinical-audit.pdf) and, for audit in a wider sphere, the Royal College of General Practitioners (RCGP) has provided ‘how to’ guidance titled [Improvement within a Primary Care Network](https://www.rcgp.org.uk/getmedia/7eb16993-d107-4346-bb81-04039f23606e/QOF-QI-PCN-how-to-guide-RCGP-2021.pdf).

Further information including the audit cycle, what can instigate an audit and the audit cycle explained can be found at [Annex A](#_Annex_A_–).

## Ethics

Clinical audits must be conducted in an ethical manner ensuring that patient confidentiality is always maintained in line with the [Data Protection Act 2018](https://www.legislation.gov.uk/ukpga/1998/29/contents) and the Caldicott principles as outlined in the **Caldicott and Confidentiality Policy**

Throughout the audit process, patient data should be anonymised and, where applicable, allocated unique identifiers.

## Results

Once an audit is complete, the results are discussed during various meetings thereby ensuring that all staff are aware of ongoing audits as well as having the opportunity to discuss the findings of audits and how the changes will be implemented across the organisation.

Dependant on usefulness, some audits can be uploaded to the organisation website while also being discussed at PPG meetings. An example of this might be an infection prevention and control audit as part of the annual IPC statement.

# Quality improvement and research

## Quality improvement

While clinical audit is a quality improvement process that seeks to improve patient care and outcomes, there are other types of quality improvement activities

These include:

* Review of outcomes data
* Small scale data searches
* Information collection and analysis (Search and Do activities)
* Plan/do/study/act (PDSA) cycles
* Significant event analysis (SEA)
* Large scale national audit
* Reflective case reviews
* Reflection on formal patient and colleague feedback survey results

Quality improvement is the responsibility of all staff, and all staff are involved in maintaining and improving the quality of services offered to our service users. While led by the management team and senior clinicians, all staff are expected to contribute to the continual development and improvement of the care that patients receive.

The RCGP advises in its document titled [Quality Improvement](https://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement) that this subject is a commitment to continuously improve the quality of healthcare by focusing on the preferences and needs of the people who use the services. It is an evidence-based approach that helps primary care to free up time to deliver initiatives and embed new approaches more effectively and efficiently into practice.

In the governmental report titled [Quality in the new health system](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213304/Final-NQB-report-v4-160113.pdf), quality is defined in terms of three criteria:

1. Clinical effectiveness (quality care is care that is delivered according to the best evidence regarding what is clinically effective in improving an individual’s health outcomes)
2. Safety (quality care is care that is delivered in order to avoid all avoidable harm and risks to the individual’s safety)
3. Patient experience (quality care is care that looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what the individual wants or needs, and with compassion, dignity and respect)

During any regulatory inspection, the CQC will expect that this organisation can demonstrate the following:

* Consider the quality of care provided
* Review the care provided in relation to current best practice guidance
* Make changes when necessary or appropriate in order to improve
* Revisit the question to see whether the changes made have resulted in an improvement

The [National Institute for Health and Care Excellence](https://www.nice.org.uk/about) (NICE) provides national guidance and advice to improve health and social care.

Further reading can be sought from The Health Foundation document titled [Quality improvement made simple](https://www.health.org.uk/sites/default/files/QualityImprovementMadeSimple.pdf).

## Quality Outcomes Framework

The Quality and Outcomes Framework (QOF) rewards practices in England for the provision of quality care while also identifying areas for improvement.

The responsibility for each element of QOF is shared across the clinical team and will be regularly reviewed by both leads and management.

## Quality improvement research

Clinical Practice Research Datalink ([CPRD](https://cprd.com/)) is a ‘real-world’ research service supporting retrospective and prospective public health and clinical studies. CPRD is jointly sponsored by the [Medicines and Healthcare products Regulatory Agency (MHRA)](https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency/) and the [National Institute for Health Research (NIHR)](http://www.nihr.ac.uk/) as part of the Department of Health and Social Care.

Organisations that sign up to join the CPRD network receive free, confidential patient safety and prescribing reports to support their quality improvement work. CPRD advises that it collects anonymised patient data from a network of GP practices across the UK. Primary care data is linked to a range of other health related data to provide a longitudinal, representative UK population health dataset. Further to this, the RCGP’s [Clinical Innovation and Research Centre](https://www.rcgp.org.uk/clinical-and-research) (CIRC) supports primary care teams to deliver better quality healthcare to their patients.

Data relating to quality improvement research can be used as evidence for appraisals, revalidation and to support work on the QOF.

# Staffing requirements

## Personnel

Staff at this organisation need to be ‘quality assured’ by means of annual appraisal, training and competences.

1. Performance appraisals

All staff will have an annual appraisal. This may be in addition to the professional appraisal or revalidation that is required for certain clinicians.

Supporting policy:

**Performance appraisal documentation**

***Performance appraisal preparation form***

***360-degree appraisal feedback form***

1. Job descriptions

To appreciate their roles, all staff have comprehensive job descriptions which clearly detail all aspects of their position, including the requirement to participate in quality improvement activity to support a culture of continuous improvement.

As roles naturally change, all job descriptions will be reviewed annually during the appraisal process. This process is to be conducted and agreed upon by both the manager and the employee to ensure that it is an accurate reflection of the role. Any specific roles are required to be added to any job description as this document supports the person and not specifically the position. An example of this would be staff who act as a Fire Warden or Chaperone.

1. Training and qualifications

All staff will be required to:

* Have the necessary qualifications and experience to undertake the role for which they are employed
* Undergo a comprehensive induction process
* Be encouraged to undertake continuous professional development
* Participate in the organisation’s training programme, including ensuring that they remain current for all mandatory courses
* Have annual appraisals
* If required, participate in the revalidation process or 360° appraisal of other staff

The CQC will expect the organisation to have enough suitably qualified, competent, skilled and experienced staff to meet the needs of those that use our service. This is to include when staff first start their employment, should they assume any new responsibilities and throughout the time at the organisation, they must remain competent to fulfil their role.

Further reading can be sought from [GP Mythbuster 70: Mandatory training considerations in general practices](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-70-mandatory-training-considerations-general-practice).

Supporting policies:

* **Staff Induction Policy**
* **Staff Development Policy – mandatory training guidelines**
* **The Training Handbook\***
* **Guidance for a new joining clinician**

\*Under review

# Other aspects of clinical governance

## Overview

Clinical governance is all-encompassing in terms of what we should be doing within our roles and there are several tools that can be used as part of the organisation’s arsenal to manage and support day-to-day requirements.

While these are listed below, greater detail relating to all aspects of clinical governance can be sought from **The Governance Handbook** and respective supporting policies.

## Policy and procedure

To ensure that the level of patient care is of the highest standards, we have policies in place which all staff are expected to read, understand and adhere to. These policies ensure a safe environment for both staff and service users.

For a list of suggested polices that may be required to support a CQC inspection can be found at Annex B of the **CQC Handbook**.

## Significant event analysis (SEA)

Refer to the **Significant Event and Incident Policy**.

## Complaints procedure

Refer to the **Complaints Procedure**.

## Compliments

Refer to the **Compliments Policy**.

## Alerts

Refer to the **Central Alerting System Policy**.

## Health, safety and risk

Refer to the **Health, Safety and Risk Management Handbook**.

## Organisational effectiveness

Further reading relating to meetings can be sought from **Management Policy and Procedures.**

# Annex A – Audits: further explained

**What can instigate an audit?**

When managing any clinical governance process, clinical audit would generally be a consideration and an audit may be generated because of any of the following:

|  |  |
| --- | --- |
| **Clinical governance process** | **Reasons to audit** |
| Complaint | Why did it go wrong, or why was it perceived to have gone wrong?Has this happened before, or what are the risks of this reoccurring?Is there is a training need and how can this be achieved?Raise a significant event to outline all the required actions and outcomes |
| Compliment | What went well and how can we continue to provide this perceived exemplary service?Is there is a training need and how can this be achieved?Raise a significant event to outline all the required actions and outcomes |
| Significant event | As alluded to, this could be either a positive or negative event, capture what was best practice, or what do not go so wellIs there is a training need and how can this be achieved?Does this need to be risk assessed?Has this happened before, or could this reoccur? |
| Managing risks | Identify a risk and how can this be mitigated as low as reasonably practicableWhat is the potential for this to be problematic or become an issue? |
| Managing issues | An issue has occurred, how do we resolve the problem? |
| Training | Is there a requirement to undertake additional training? |
| Meeting | Following any of the above, this needs to be discussed and minuted.Consider all the above and undertake an audit |

**The audit-cycle**

Below is the process of the audit cycle in diagrammatic form:

**The audit cycle explained**

The diagram below shows how the need to audit can be identified: