Leicestershire Partnership NHS Trust

Quality Improvement, Clinical Audit, and Service Evaluation

This policy sets out the processes for undertaking and reporting quality improvement activity including, but not limited to, PDSA, clinical audit and service evaluation.

Key words: Policies, Clinical Audit, PDSA, Service Evaluation, Clinical Effectiveness, Quality Improvement

Version: 1.0

Approved by: Clinical Effectiveness Group

Ratified By: Quality Forum

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Type of Policy: clinical and non-clinical

Contents

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SUMMARY & AIM

The purpose of this policy is to ensure that Leicestershire Partnership NHS Trust (LPT) meets its statutory and mandatory requirements for clinical audit and uses quality improvement methodologies to demonstrate effectiveness, drive improvement and share learning. It sets out a framework for staff carrying out clinical audit, service evaluation and PDSA projects in LPT. These processes should provide evidence of effectiveness for assurance, plans for and evidence of improvement, and learning that can be shared across the organisation.

TARGET AUDIENCE:

All LPT staff.

TRAINING

Variety of training packages provided by WeImproveQ.

KEY REQUIREMENTS

This policy is intended for use by all LPT staff participating in and responsible for using these processes. This policy also applies to employees of partner organisations conducting clinical audit, evaluation or quality improvement with staff, patients or data from this trust.

This policy defines roles and responsibilities for conducting these activities. The appendices include definitions of each of these methods and details the processes required to undertake them.

1.0 Quick look summary

The purpose of this policy is to ensure that Leicestershire Partnership NHS Trust (LPT) meets its statutory and mandatory requirements for clinical audit and uses quality improvement methodologies to demonstrate effectiveness, drive improvement and share learning. It sets out a framework for staff carrying out clinical audit, service evaluation and PDSA projects in LPT. These processes should provide evidence of effectiveness for assurance, plans for and evidence of improvement, and learning that can be shared across the organisation.

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Clinical Audit

Clinical audit measures the quality of care and services against agreed standards, identifying areas where improvements are necessary.

Service Evaluation

Service evaluation examines existing or newly implemented services to determine to determine such aspects as effectiveness, efficiency, equability and so forth. This process explores what is happening in a service as well as outcomes and experience for patients.

Quality Improvement (QI)

QI is a systematic process using QI theory and methods to continually make small changes that lead to measurable improvements for targeted services or patient populations.

Statutory and Mandatory requirements

Healthcare providers must participate in relevant national clinical audits within the National Clinical Audit and Patient Outcomes Programme (NCAPOP). Healthcare providers must also review and implement relevant recommendations of any national clinical audit (NHS Standard Contract).

Healthcare providers must implement a programme of clinical audit (NHS Standard Contract) to regularly assess and monitor the quality of the services provided (CQC

Essential Standards). They must use the findings from clinical and other audits to ensure that action is taken to protect people who use services from risks associated with unsafe care, treatment and support (CQC Essential Standards).

Healthcare providers must produce an annual Quality Account, which must include information on participation in national and local audits, and the actions that have been taken to improve services, as a result of audits (NHS Quality Account Regulations, 2017).

1.1 Version control and summary of changes

Version number	Date	Comments (description change and amendments)

For Further Information Contact:

1.2 Key individuals involved in developing and consulting on the document

Name	Designation
Bhanu Chadalavada	Medical Director
Carl Lomas	Quality and Data Analyst
Jasmine Feakes	Senior Clinical QI Advisor
Julian Coleman	QI Practitioner
Nicola Hurton	QI Practitioner
Elena Relph	QI Practitioner
Julie Warner-Williams	QI Practitioner
Heather Darlow	Trust Lead for Quality Improvement and Clinical Quality Governance
Andrew Moonesinghe	Pharmacy Services Manager
Deanne Rennie	Associate Director of AHPs and Quality
Alison Kirk	Head of Patient Experience and Involvement
Tim O'Donovan	Deputy Director of Transformation
Gemma Barfoot	Head of Programme Management
Dave Clarke	Head of Research Operations
Trust Policy Experts	

1.3 Governance

Level 2 or 3 approving delivery group – Clinical Effectiveness Group

Level 1 Committee to ratify policy – Quality Forum

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

If you would like a copy of this document in any other format, please contact lpt.corporateaffairs@nhs.net

1.5 Due Regard

LPT will ensure that due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy

1.6 Definitions that apply to this policy.

Clinical audit: 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. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement in healthcare delivery

Clinical Effectiveness: The application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients.

Clinical Quality Governance: Clinical quality governance is a term used to describe a systematic approach to maintaining and improving the quality of patient care within a health system. It can be defined as a framework through which NHS organisations are accountable for continually improving the quality of their services and

safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Consent: a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

- be competent to take the particular decision;
- have received sufficient information to take it and not be acting under duress.

Due Regard: Having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Plan, do study, act (PDSA): The PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act).

Patient Safety Incident Response Framework (PSIRF): Patient Safety Incident Response Framework is the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Quality Improvement (QI): Improving quality is about making healthcare safe, effective, patient-centred, timely, efficient and equitable. Quality Improvement is a systematic approach that uses specific techniques to improve quality

Research: The HRA defines research as, "The attempt to derive generalisable or transferable new knowledge to answer questions with scientifically sound methods including studies that aim to generate hypotheses as well as studies that aim to test them, in addition to simply descriptive studies."

Service Evaluation: Service evaluation is a methodology to support service improvement by looking at the quality of the content, the delivery process and the impact of the activity or programme on the audience or participants.

Step Up To Great: LPT's strategy which outlines how we will build on the solid foundation we have created, to help deliver our vision of 'creating high quality compassionate care and wellbeing for all'.

WeImproveQ: The trust's approach to quality improvement, based on six key principles: one shared approach; knowledge and skills, working in partnership; continued improvement; sharing good practice; data for measurement.

2.0 Purpose and Introduction/Why we need this policy

The purpose of this policy is to set out a governance and ethical framework for the conduct of quality improvement (an umbrella term encompassing Clinical Audit, Service evaluation and PDSA). This will ensure quality improvement is embedded as an activity across the Trust and ensure current approaches to clinical practice are reviewed against pre-determined standards, leading to improvements and enhancements in care provision. Whilst QI is fundamentally about improving quality, it also plays an important role in providing Board assurances regarding the quality of services.

This policy sets out the responsibilities for all staff carrying out QI and outlines the Trust's expectations in relation to training of staff, registering, developing, carrying out and monitoring of all QI projects.

This policy provides:

- Expectations in relation to conduct, and participation in QI.
- The procedures and expectations for initiating QI project proposals.
- Guidance for all staff in QI activities and processes, including dissemination of results and sharing lessons learnt.
- The procedures that should be followed in order to make changes and sustain them.
- An outline of support available from the WeImproveQ team.
- The WeImproveQ Team is committed to ensuring that QI projects are carried out in accordance with the principles of best practice.

This policy aims to:

- Improve outcomes for patients.
- Encourage patient, carer and public involvement in the QI process.
- Ensure that QI projects are relevant to Trust business.
- Drive and monitor clinical improvement and implement changes to practice.
- Reduce variation in the quality of healthcare.
- Maximise the effective use of limited resources.
- Ensure that all staff are supported and encouraged to participate in QI.
- Encourage multidisciplinary QI projects and closer working relationships within multidisciplinary teams.
- Contribute to the continued professional development of staff.

- Provide assurance that our services are safe, of a high quality and meet local, regional and national standards.
- Provide assurance against relevant indicators which are monitored through the Integrated Quality & Performance Report (IQPR).
- Ensure appropriate quality controls are put in place.

QI is a key element of a learning culture, allowing improvements to be developed locally before sharing the learning and adoption of the change elsewhere. Systems thinking and human factors are an integral part of all QI processes. WeImproveQ aims to maximise these aspects through working in partnership with improvement and learning focused trust groups such as the Corporate Patient Safety Team and their implementation of PSIRF.

Ethics is an important aspect of all healthcare activities and QI is no exception. This policy and its attendant processes have been formulated to support the inclusion and oversight of ethics within all QI activities.

Quality improvement within the trust is closely aligned to the transformation work programme and oversight of PDSA QI projects and the QI programme is overseen here.

3.0 Policy Requirements

3.1 Patient and Public Involvement

Patients and carers are key stakeholders in the quality improvement process and patients, patient representatives and relevant patient organisations should be involved at all stages of the QI process as equal members of the project team, where appropriate and feasible.

The Trust promotes the involvement of patients/carers in the QI process either indirectly through the use of experience evidence captured through patient feedback and engagement. Directly through partnerships and the participation of individuals as project partners or as members of project teams.

3.2 Multidisciplinary QI and partnership within LPT

The Trust supports the development of QI projects across professional groups, both clinical and non-clinical, and across MDTs to encourage system thinking and sharing of learning across the trust.

3.3 Multidisciplinary QI and partnership working with other organisations

The Trust encourages QI projects that are undertaken jointly across professions and across organisational boundaries working within the health and social care system where improvements to the patient journey may be benefited through shared QI working.

4.0 Duties within the Organisation

4.1 Medical Director

The Medical Director has a shared portfolio with the Director of Nursing, AHPS and Quality, being the Executive Lead for clinical audit and NICE. Where appropriate the Medical Director informs the Trust Board of clinical audit activities that provide assurance on clinical effectiveness and for the mitigation of risks recorded on the Corporate Risk Register and the Board Assurance Framework (BAF).

4.2 Director of Nursing, AHPs and Quality

The Director of Nursing, AHPs and Quality has a shared portfolio with the Medical Director being the Executive Lead for the Quality Improvement agenda. Where appropriate the Director of Nursing, AHPs and Quality informs the Trust Board of quality improvement activities that provide assurance on clinical effectiveness and for the mitigation of risks recorded on the Corporate Risk Register and the Board Assurance Framework (BAF).

4.3 Associate Director of AHPs and Quality

The Associate Director of AHPs and Quality is responsible for coordinating the Trust's clinical quality governance assurance agenda including quality improvement. This includes developing and implementing strategies, policies and systems and performance measurements to deliver the requirements of independent regulators such as the Care Quality Commission and NHS Impact.

4.4 Trust Lead for Quality Improvement and Quality Governance

The Trust Lead for Quality Improvement and Quality Governance provides visible and effective trustwide strategic leadership for clinical and quality governance and quality improvement, including ensuring compliance with NICE standards, delivery of the trust wide clinical audit programme and QI programme.

In conjunction with the Audit and Risk Committee, Medical Director, Clinical Directors, Clinical Quality Governance Leads and the Associate Director of AHPs and Quality, the Trust Lead for Quality Improvement and Quality Governance is responsible for ensuring that the clinical audit forward plan is relevant, supports service delivery and includes clinical audits specified within national, regional and local guidelines and performance targets.

4.5 Clinical and Quality Governance Leads

- Ensuring that the results of clinical audits and service evaluations inform and influence clinical practice and staff training needs within the Services.
- Ensuring each Directorate Management Teams with responsibility for quality improvement has effective representation from all Service areas.
- Identifying priority level one and two projects (see section 8.1 for priority levels) to be approved by subgroups of the Quality Forum (QF) e.g. outcomes of CQC visits.
- Assisting in the identification of service leads for relevant priority level one and two projects.
- Working with the Quality Improvement Advisors to:
    - Ensure priority level three and four projects are logged and tracked on the appropriate Trust quality improvement platform.
    - Identify opportunities for priority level three projects (see section 8.1 for definition of priority levels).
    - Ensure there is a system in place for the dissemination of results and the escalation of any risks / concerns to the relevant Trust governance group.
    - Ensure projects are closed down appropriately.

4.6 WeImproveQ Team

- Ensures the Trust is using appropriate software tools to support projects.
    - Where this is third party software to provide internal support and act as point of contact with suppliers.
    - To create and maintain internal tools where appropriate third party software is not available.
- Advice about the use of appropriate measures
- Routinely update CEG and Transformation and QI Delivery Group on progress and delivery
- With CEG determine which national audits are suitable for participation and identify leads

- Will produce an annual clinical audit forward plan for clinical audits approved by the CEG or relevant subgroup of the QF, or the Directorate / Service Governance Groups with responsibility for clinical audit. Progress against the plan and any areas of concern are reported to the CEG (or other relevant subgroup of the QF) and Directorate / Service Governance Groups with responsibility for clinical audit.
- Regular reporting to the Audit and Assurance Committee
- Monitors quality of QI projects including impact and outcome
- Provides support to QI projects as appropriate for each project's priority
- Ensuring that all clinical audits compare practice to agreed standards of best practice.
- Reviewing project initiation documents and reports for all level clinical audits.
- Advising on the development of and reviewing action plans and change ideas to ensure they are effective.
- Working with the Patient and Carer Experience team to promote patient and carer involvement in QI.
- Encouraging QI Project Leads to engage in multidisciplinary and interface QI projects.
- Support the delivery of the blended training triangle

4.7 QI Project Lead

Each QI project has a QI Project Lead from the service.

Their duties include:

- To work in conjunction with WeImproveQ, having regular contact with your allocated QI Advisor and informing them of when communication messages regarding the project are being planned, e.g. through the LPT's e-newsletter, or on the intranet.
- To update QI project support systems (as appropriate), being mindful that governance oversight through LPT's meeting structures and to interested Directorates will be via these platforms.
- To establish measures to demonstrate if changes made have resulted in improvements.
- Ensuring that all clinical audits compare practice to agreed standards of best practice.
- To recognise and value others' differences within the project team and demonstrate LPT values and leadership behaviours at all times, and work with others to maintain a culture of psychological safety where all feel able to contribute.
- In conjunction with the Trust's Patient Experience and Involvement Team, to identify the opportunities within the project for patient and carer involvement, and to provide the support required for any patient/carers within their project team.

- To evaluate the project itself and to remain alert to further learning that arises from the project.
- To consider the individual aspects of sustainability and so seek to safeguard its future by strengthening the chances of the changes made being sustainable.
- To consider the need for continuity of leadership should the Lead, leave the Trust, or their role within the Trust changes.
- To ensure collation of findings and feedback of these through the expected project report formats.
- To consider submitting e-newsletter pieces, publications to appropriate journals, and presentations / posters within and external to LPT.
- Make use of the resources on the WeImproveQ intranet page, QI training sessions, and QI drop-in sessions when necessary.
- To consider the ethical implications for any activity being undertaken

4.8 Senior Leaders

- To support the embedding of QI routines and practices into everyday practice
- To take responsibility for their own knowledge and understanding of quality improvement and to support staff in accessing QI training opportunities and leading the way in utilising these skills in practice.
- To be problem framers and not problem solvers.

4.9 Directorate Management Teams

- Encourage multidisciplinary QI projects and interface QI projects with partner organisations where appropriate.
- Promote patient and carer involvement in QI.
- Ensure that QI projects are conducted within an ethical framework and in line with this policy.
- Promote effective clinical audit based on evidence-based criteria.
- Receive clinical audit reports and agree a re-audit date or other appropriate quality improvement work.
- Promote re-audit where there is a need to improve care and agree a rationale where re-audit is not required (to be recorded in the minutes).
- Review, approve and monitor the implementation of change.
- Provide the WeImproveQ team with updates on the status of actions monitored by the group, providing evidence of implementation where possible.
- Review progress against the annual clinical audit forward plan.
- Promote the WeImproveQ page on the Trust intranet.
- Promote associated training and support.

4.10 All LPT Clinical Staff

All staff will participate in QI through any of the following:

- Leading.
- Collecting data/measures.
- Implementing change ideas.
- Implementing actions resulting from the findings of clinical audit.

Professional staff are individually accountable for ensuring they audit their own practice as defined by their respective professional codes of conduct.

4.11 Trust Board

The Trust Board has a role in driving quality through checks on compliance to care delivery standards. The Trust Board has the responsibility to use QI activities as an assurance tool including for the mitigation of risks related to clinical effectiveness recorded on the Organisational Risk Register (ORR) and supported through sub-committee reporting.

4.12 Quality Forum (QF)

The QF is authorised by the Trust Board to monitor the Trust's quality strategies and to provide the Trust Board with assurance on quality Key Performance Indicators (KPIs) and deliverables which includes quality improvement and effectiveness.

4.13 Clinical Effectiveness Group (CEG) and other subgroups of the QF

The CEG has responsibility for developing a strategy improving and maintaining effectiveness, which includes:

- Setting priorities
- Participation in national and regional clinical audit.
- Establishing and monitoring progress against a clinical audit forward plan.

The CEG maintains an overview of all priority QI projects relating to clinical care.

Some projects will be considered by specialist groups that report to the sub-groups of the QF. For example:

- Electroconvulsive Therapy (ECT) Steering Group
- Medicines Audit Group (MAG)

4.14 Audit & Risk Committee

The Audit & Risk Committee is responsible for ensuring that the clinical audit forward plan is relevant, supports service delivery and includes clinical audits specified within national, regional and local guidelines and performance targets.

4.15 Transformation and Quality Improvement Delivery Group (TQIDG)

The TQIDG oversee the delivery of LPT Transformation and Quality Improvement plans, projects, and programs of work and to ensure service improvements are delivered at pace for patients, staff, and local residents of LLR

5.0 Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent if they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.

In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- Understand information about the decision
- Remember that information
- Use the information to make the decision
- Communicate the decision

6.0 Monitoring Compliance and Effectiveness

Page/Section	Minimum Requirements to monitor	Method for Monitoring	Responsible Individual /Group	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group). Frequency of monitoring
Training uptake and quality	Number of participants	Attendance at training recorded on WeImproveQ training tracker	WeImproveQ team	Biannual reporting to TQIDG
Training uptake and quality	Participant feedback	Link to online feedback form provided to attendees.	WeImproveQ team	Biannual reporting to TQIDG
Effectiveness of QI process	Adherence to process and outcome of projects	Audit of sample of projects for each methodology	WeImproveQ team	Annual reporting to TQIDG of audit results and action plan.
Spread of Learning	Number of easy read project reports shared (e.g. storyboards)	WeImproveQ team recording of reports produced	WeImproveQ team	Annual Reporting to TQIDG of number of reports produced
Spread of Learning	Attendance at QI events	WeImproveQ team recording attendance at each event	WeImproveQ team	Annual Reporting to TQIDG of attendance

7.0 References and Bibliography

None.

Include a list of all documents referred to in the Policy including those from other Trust's policies. The date of the document should be included. Do not include electronic links or embedded documents to other policies/guidelines and are in a standard format.

8.0 Fraud, Bribery and Corruption consideration

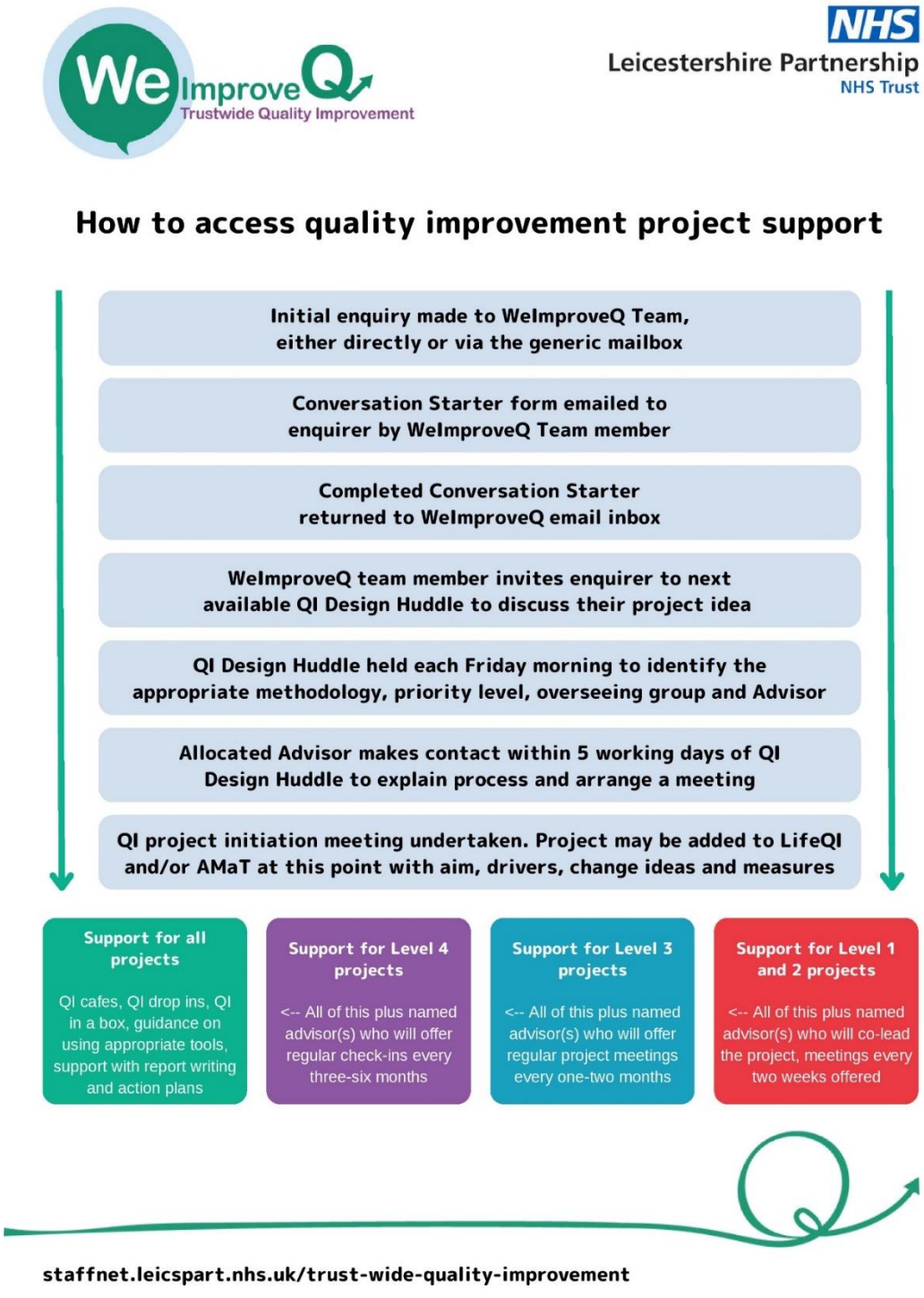
The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

Appendix 1 Flowchart of accessing quality improvement support



Appendix 1 Training Needs Analysis

Training topic:		
Type of training: (see study leave policy)	Desirable	
Directorate to which the training is applicable:	Adult Mental Health Community Health Services Enabling Services Families Young People Children / Learning Disability/ Autism Services Hosted Services	
Staff groups who require the training:	All	
Regularity of Update requirement:	None	
Who is responsible for delivery of this training?	WeImproveQ	
Have resources been identified?	Yes	
Has a training plan been agreed?	Yes	
Where will completion of this training be recorded?	uLearn WeImproveQ will maintain its own list of training delivered for the purpose of monitoring the quality and effectiveness of training offered and delivered.	
How is this training going to be monitored?		
Signed by Learning and Development Approval name and date		Date:

Appendix 2 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers Answer yes/no to all

Respond to different needs of different sectors of the population yes/no

Work continuously to improve quality services and to minimise errors yes/no

Support and value its staff yes/no

Work together with others to ensure a seamless service for patients yes/no

Help keep people healthy and work to reduce health inequalities yes/no

Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance yes/no

Appendix 3 Due Regard Screening Template

Section 1	
Name of activity/proposal	Quality Improvement, Clinical Audit, and Service Evaluation
Date Screening commenced	06/02/2024
Directorate / Service carrying out the assessment	WeImpoveQ
Name and role of person undertaking this Due Regard (Equality Analysis)	Carl Lomas, Quality and Data Analyst
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: To update the quality improvement policy to better reflect best practice and the procedures used at LPT	
OBJECTIVES: A quality improvement policy that accurately reflects best practice and the procedures used at LPT	

Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details
Age	None
Disability	None
Gender reassignment	None
Marriage & Civil Partnership	None
Pregnancy & Maternity	None
Race	None
Religion and Belief	None
Sex	None
Sexual Orientation	None
Other equality groups?	None

Section 3	
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.	
Yes	No ✓
High risk: Complete a full EIA starting click here to proceed to Part B	Low risk: Go to Section 4.

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
This policy covers the internal processes governing quality improvement, not the aspects of quality improvement that could affect protected characteristics, for example choice of audit topic			
Signed by reviewer/assessor	Carl Lomas	Date	06/02/2024
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Heather Darlow	Date	06/02/2024

Appendix 4 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy. The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.			
Name of Document:	Quality Improvement, Clinical Audit, and Service Evaluation		
Completed by:	Carl Lomas		
Job title	Quality and Data Analyst		**Date** 06/02/2024
Screening Questions		**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.		No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.		No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?		No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.		No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?		No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.		No	
8. Will the process require you to contact individuals in ways which they may find intrusive?		No	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.	
Data Privacy approval name:	
Date of approval	

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust