

# **Clinical Audit Annual Report**

## **University Hospitals of Morecambe Bay NHS Foundation Trust 2014 -15**

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**Approved by: Quality Committee 15 June 2015**

*Clinical audit - tool to promote quality for better health services*

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## Introduction

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Clinical audit forms an integral part of the clinical governance 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. Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic measurement against explicit criteria and the implementation of any necessary change(s): *New Principles of Best Practice in Clinical Audit, Healthcare Quality Improvement Partnership, 2<sup>nd</sup> Edition, 2011*.

In order to support robust and effective clinical audit activity the Clinical Audit Department has, in previous years, worked to the Trust's Clinical Audit Policy, which had been developed and implemented in 2011. This document was due for review during 2014/15 and has subsequently been superseded by the Clinical & Non-clinical Audit Procedure document, which was ratified in October 2014. The purpose of the procedure is to sustain a culture of best practice in clinical audit and it clarifies the roles and responsibilities of staff engaged in the clinical audit process within UHMBFT. Its aim is to encourage and facilitate good quality clinical audit from all staff tasked with undertaking an audit project.

The Clinical Audit Department maintains a Trust-wide clinical audit database of all clinical audit activity. It also maintains electronic records of completed projects, which include:

- Proposal forms outlining defined criteria and measurable standards
- Presentations / reports
- Summary sheets of data collated and analysed
- Completed action plans outlining opportunities for improvement(s)

In addition, audit presentations are available in PDF format on the Trust intranet along with a range of audit tools, materials and templates for reporting findings, formalising actions and facilitating meetings.

A Clinical Audit Facilitator is assigned to each division in order to support Clinical Audit Leads with the delivery of clinical audit progress reports for priority level 1-4 audits, for which definitions are provided below. The plan is divided into 4 distinct elements and is in line with national guidance from the Healthcare Quality Improvement Partnership (HQIP). Clinical audits are prioritised into one of four levels, as per the table below (Table 1), with Level 1 being given the highest priority.

### Priority Levels for Clinical Audits: HQIP Definition

*Level	**Audit Type	
Level 1 audits, 'external must dos'	<ul style="list-style-type: none"> <li>• National audits (NCAPOP)</li> <li>• NCEPOD / Confidential Inquires</li> <li>• NICE</li> <li>• CQUIN</li> <li>• CQC</li> <li>• Quality Schedules</li> <li>• DH statutory requirements (e.g. Infection Control Monitoring)</li> </ul>	1
Level 2 audits, 'internal must dos'	<ul style="list-style-type: none"> <li>• Clinical risk</li> <li>• Serious untoward incidents</li> <li>• Complaints</li> <li>• Re-audit</li> </ul>	2
Level 3 audits, 'divisional priorities'	<ul style="list-style-type: none"> <li>• Local topics important to the division</li> </ul>	3
Level 4 audits	<ul style="list-style-type: none"> <li>• Clinician / personal interest</li> <li>• Educational audits</li> <li>• SSMs / SAMP</li> </ul>	4

Table 1

All NHS organisations are required to have in place a comprehensive programme of quality improvement activities that includes healthcare professionals participating in regular clinical audit. Clinical audit is the governance vehicle in relation to clinical practice, and is integral to the core business of the Trust.

The Clinical Audit Department is committed to raising the profile of clinical audit within the Trust and is dedicated in its aim that the annual forward audit programme should be a valuable resource in the Trust's aim to continually improve patient outcomes and experience and to provide assurance in areas in which this is already demonstrated. The Trust-wide Forward Audit Programme 2014-15 was implemented at the start of the business year following approval by the Clinical Governance & Quality Committee.

The formulation of this system acts as a driver for the divisions and specialties to assess and determine their priorities and to predict and plan their audit activity, where possible, to flow throughout the forthcoming year. The Clinical Audit Department recognises that it is not possible to anticipate all necessary activity and, therefore, pro-actively accommodates additional and / or repeat projects that are required due to unfolding Trust priorities throughout the year.

This report summarises the activity undertaken from the Clinical Audit Annual Programme 2014-15, as collated by the Clinical Audit Department in collaboration with the clinical audit specialty leads and divisions and including all relevant national audit projects in which the Trust is eligible to participate. It also reports on projects undertaken as additional projects which are submitted throughout the year.

### Clinical audit project statistics for 2014/2015

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The table below (Table 2) demonstrates the breakdown of audit activity by division between 1st April 2014 and 31st March 2015. At the close of 2014/15 there were 258 audits identified on the clinical audit progress report, this included topics from the audit forward programme, plus additional audits added to the plan throughout the year. Of these 214 (83%) have been completed. However, that those audits recorded as being incomplete are, in fact, ongoing. It must be noted that it is not always possible to complete every project by the end of the financial year and some of these topics may be due for completion in the near future or may require extensive timeframes in order to yield sufficient cohorts to the audit samples.

We are extremely pleased to note that the completion rate of 83% is markedly higher than that of the previous year (58%). This is primarily due to the support of the Clinical Audit & Effectiveness Steering Group and the accountability it engenders to auditing clinicians

<b>Division</b>	<b>N</b>	<b>N completed</b>	<b>% completed</b>
Core Clinical Services	54	50	93%
Acute Medicine	14	13	93%
Elective Medicine	30	23	77%
Surgery & Critical Care	115	87	76%
WACS	45	41	91%
<b>Total</b>	<b>258</b>	<b>214</b>	<b>83%</b>

Table 2

## Participation in National Clinical Audits and National Confidential Enquiries

The NHS standard contracts for acute hospital; mental health; community and ambulance services set a requirement that provider organisations participate in appropriate national clinical audits that are part of the National Clinical Audit and Patient Outcome Programme (NCAPOP). This is in line with the government's intention to see increased accountability and transparency in the public sector.

The Healthcare Quality Improvement Partnership (HQIP) hosts the contract to manage and develop the NCAPOP, which comprises clinical audits that cover care provided to people with a wide range of conditions.

### University Hospitals of Morecambe Bay NHS Foundation Trust participation 2014/15

<b>Project type</b>	<b>Eligible for participation</b>	<b>Number in which participated</b>	<b>Percentage of participation</b>
<b>National Audits (NCAPOP)</b>	33	31	94%
<b>Confidential Enquiries (NCEPOD)</b>	2	2	100%

Table 3

There were 2 national audits the Trust decided not to participate in. The National Comparative Audit of Blood Transfusion programme - sickle cell disease, this was due to very low numbers so the Trust opted out. The National Adult Diabetes Audit was due to the size of the audit, a lack of accessible data to enable the Trust to provide the data and no support or resource available to deliver it. Now that our Trust uses LORENZO it may be more realistic to look at this again for the future in terms of planning what data can be pulled directly from the IT system to be submitted.

## National Clinical Audits

The national clinical audits and national confidential enquiries in which University Hospitals of Morecambe Bay NHS Foundation Trust participated during 2014/15, and for which data collection was completed during 2014/15, are listed in Column A of Tables 4 and 5 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry identified in Column B and C of Tables 4 and 5.

### Trust Participation in National Clinical Audits

<b>Table 4</b>				
<b>List of National Clinical Audits in which University Hospitals of Morecambe Bay NHS Foundation Trust was eligible to participate during 2014/15</b>				
<b>Number</b>	<b>Title of National Clinical Audit</b>	<b>Column A Participate</b>	<b>Column B Cases Submitted</b>	<b>Column C Cases submitted (% of cases required)</b>
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Continuous	Ongoing
2	Adult Community Acquired Pneumonia	Yes	Still open	Ongoing
3	Bowel cancer (NBOCAP)	Yes	Continuous	Ongoing
4	Cardiac Rhythm Management (CRM)	Yes	Continuous	Ongoing
5	Case Mix Programme (CMP)	Yes	Continuous	Ongoing
6	Diabetes (Adult)	No		
7	Diabetes (Paediatric) (NPDA)	Yes	Still open	Ongoing
8	Pregnancy in Diabetes	Yes	FGH (3) RLI (5)	
9	Epilepsy 12 audit (Childhood Epilepsy)	Yes	FGH (4) RLI (18)	
10	Falls and Fragility Fractures Audit Programme (FFFAP) - National Hip Fracture Database (NHFD)	Yes	Continuous	Ongoing
11	Fitting child (care in emergency departments) (CEM)	Yes	FGH (15)	
12	Head and neck oncology (DAHNO)	Yes	Continuous	Ongoing
13	Inflammatory Bowel Disease (IBD)	Yes	Continuous	Ongoing
14	Lung cancer (NLCA)	Yes	Continuous	Ongoing
15	Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	Continuous	Ongoing
16	National Cardiac Arrest Audit (NCAA)	Yes	Continuous	Ongoing
17	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme Pulmonary Rehab	Yes	62 (FGH) 100 (RLI)	
18	National Comparative Audit of Blood Transfusion programme - patient information & consent	Yes	RLI (14) FGH (9)	58% 38%
19	National Comparative Audit of Blood Transfusion programme - sickle cell disease	No	Trust opted out as not enough patients	N/A
20	National Emergency Laparotomy Audit (NELA)	Yes	Continuous	Ongoing
21	National Heart Failure Audit	Yes	Continuous	Ongoing
22	National Joint Registry (NJR)	Yes	Continuous	Ongoing

23	National Prostate Cancer Audit	Yes	Continuous	Ongoing
24	National Vascular Registry	Yes	Continuous	Ongoing
25	Neonatal Intensive and Special Care (NNAP)	Yes	Continuous	Ongoing
26	Oesophago-gastric cancer (NAOGC)	Yes	Continuous	Ongoing
27	Older people (Care in Emergency Departments) (CEM)	Yes	100	100%
28	Paediatric Intensive Care Audit Network (PICANet)	Yes	Continuous	Ongoing
29	Pleural Procedure	Yes	8	100%
30	Rheumatoid and Early Inflammatory Arthritis	Yes	Continuous	Ongoing
31	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Continuous	Ongoing
32	Mental Health (CEM)	Yes	FGH (21) RLI (34)	
33	Elective surgery (National PROMs Programme)	Yes	Continuous	Ongoing

Table 4

## National Confidential Enquiries

<b>Table 5: List of National Confidential Enquires that University Hospitals of Morecambe Bay NHS Foundation Trust was eligible to participate in during 2014/15.</b>				
Number	Title of National Confidential Enquiries	Column A Participate In	Column B Cases submitted	Column C Cases submitted (% of cases required)
1	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	Ongoing/Continuous	
2	Sepsis (NCEPOD)	Yes	RLI (4) FGH (2)	100%
3	Gastrointestinal bleeding (NCEPOD)	Yes	RLI (4) FGH (5)	100%
4	Acute Pancreatitis (NCEPOD)	Yes	Starts March 2015	
5	Mortality reviews (NCEPOD)	Yes	1	100%

Table 5



## Local Recommendations Made Following Participation in National Clinical Audits 2014-15: Reported On

**Table 6 – list of recommendations made following participation in National Clinical Audits**

Title of National Clinical Audit reports received in 2014/15	Details of actions taken or being taken to improve the quality of local services and the outcomes of care.
<b>National Audit of Patient Information and Consent</b>	<ul style="list-style-type: none"> <li>Email clinical and governance leads with link to patient information leaflet ordering site.</li> <li>Email clinical and governance leads with results of actions required</li> <li>Present audit findings at divisional audit meetings</li> <li>Re-audit January 2015</li> </ul>
<b>Massive Haemorrhage Audit</b>	<ul style="list-style-type: none"> <li>Re-write Massive Haemorrhage Policy</li> <li>Re-audit monthly</li> </ul>
<b>National Chest Drain Audit</b>	<ul style="list-style-type: none"> <li>Re-launch new care plan in Emergency Department, AMU and ITU</li> <li>Pleural procedure room on respiratory ward</li> <li>Use of bedside ultrasound for pleural effusions</li> <li>Standardised single chest drain kit for the whole Trust</li> <li>Re-audit</li> </ul>
<b>National Lung Cancer Audit</b>	<ul style="list-style-type: none"> <li>Improve presence of Lung Cancer specialist Nurse at Diagnosis:</li> <li>Plan: Increase hours/WTE number for LCNS</li> <li>Improve attendance of Surgeons in LCMDT</li> <li>Improve core-members attendance in LCMDT</li> <li>Improve rate of Histological diagnosis</li> </ul>
<b>Intensive Care National Audit and research Centre (ICNARC)</b>	<ul style="list-style-type: none"> <li>Improve co-operation from all medical staff in the coding process which will maintain a good data processing time. Data processing should ideally be completed on the day of admission and daily thereafter</li> <li>Provide data to support the business case for an outreach 24 hour/7 day per week outreach service on site.</li> <li>Reduction / Review of 'Early Deaths' – Each case to be reviewed to determine if these have been avoidable or not, all information will be passed to the CCDG for case review</li> <li>Improve assessment of the critically ill patient on site in terms of assessing the appropriateness and timeliness of admission to ICU.</li> <li>Reduction in the number of out of hour, early and delayed discharges Improved communication from critical care via the daily bed management meetings (proforma in draft stage), to be presented by the nurse in charge or unit managers</li> <li>All out of hours discharges / delayed discharges to be reported as an adverse incident on Ulysses system</li> <li>All out of hours discharges / delayed discharges to be case reviewed and presented for discussion at the CCDG to inform service development</li> <li>Improve infection acquisition rates (MRSA, CDFF)</li> <li>All acquired infections to be reported as an adverse incident</li> <li>All acquired infections to be reviewed as an RCA</li> <li>All RCA findings to be implemented and shared as part of unit governance and ongoing protocols / procedures in terms of infection prevention to be adhered to Improve ventilation weaning procedures.</li> <li>Local protocol has been devised for team discussion</li> <li>Implementation of the protocol / education</li> <li>Purchase of the NAVA software for the Maquet ventilators via charitable funds</li> </ul>
<b>National audit of Heart Failure</b>	<ul style="list-style-type: none"> <li>Ensure correct coding of patients discharged with a diagnosis of heart failure- significant over and is diagnosis of patients in UHMBFT.</li> <li>Ensure patients with HF are seen by a member of the cardiology/ HF team before DC. Additional HF nurse resource required especially to cover weekends as well as mandating all non-cardiologists refer the patients- some colleagues still do not do so despite advice</li> </ul>

	<ul style="list-style-type: none"> <li>• Treatment on a specialist ward is not possible at UHMBFT as we have no dedicated cardiology wards other than CCUs</li> <li>• Review within 2 weeks after DC- this is achieved if the patient is referred to the HF team – see second point2 above</li> <li>• Treatment with appropriate HF medications is achieved when the patient is referred to the HF team</li> <li>• Ensure HF nurses are appropriately funded to allow upload of data to the national HF database- we achieved few entries in 12-13 as there were no HF nurses before that point - next year's compliance will be much better but this take up a lot of their time.</li> </ul>
<b>National Paediatric Diabetes Audit</b>	<ul style="list-style-type: none"> <li>• Further improving mean HbA1c and also number of children with HbA1c less than 58 mmol/mol by robustly adopting SOP- for example high HbA1c policy</li> <li>• Provide more support to all the diabetes patients- DNS employed, diabetes night on call service, more dietetic time, transitional clinics</li> <li>• Provide Psychology Service – Clinical Psychologist employed in 2014</li> <li>• Further Improve team communications and help in diabetes data management and audits including NPDA - Data Manager employed.</li> <li>• Diabetes teaching to all medical and nursing staff</li> <li>• School education programme</li> <li>• National diabetes audit annually</li> </ul>
<b>Sentinel Stroke National Audit (SSNAP)</b>	<ul style="list-style-type: none"> <li>• SSNAP Action plan reported through Quality Committee.</li> </ul>
<b>National Paediatric Asthma Audit</b>	<ul style="list-style-type: none"> <li>• Refer to Respiratory Nurse all asthma admissions.</li> <li>• Arrange follow up with GP within a week post admission and document.</li> <li>• Check and document device technique before discharge – design a checklist to include in discharge pack. Discharge document being revised to include inhaler technique in the checklist</li> <li>• Information leaflet for all admissions</li> <li>• Check/Document Peak Expiratory Flow Rate (PEFR) in patients above 5 years</li> <li>• Asthma Management Plan given at discharge to all patients and documented in notes</li> <li>• Continue data input over longer period using the national audit tool to improve number for comparison.</li> <li>• New doctors awareness (induction)</li> </ul>
<b>British Thoracic Society National Bronchiectasis audit</b>	<ul style="list-style-type: none"> <li>• Sputum sample prior to starting antibiotics</li> <li>• Recommended Screening for treatable causes – Allergic Bronchopulmonary Aspergillosis (ABPA), Combined Variable Immune Deficiency (CVID), Cystic Fibrosis (CF).</li> <li>• Access to pulmonary rehabilitation</li> <li>• Improve recording of useful clinical information relating to exacerbations in community</li> <li>• Education in secondary and primary care about bronchiectasis</li> </ul>
<b>Cardiac Rhythm Management (CRM)</b>	<ul style="list-style-type: none"> <li>• Increase implant rate of brady pacemakers</li> <li>• Increase implant rate of complex devices especially Implantable Cardioverter Defibrillators (ICD).</li> </ul>
<b>MINAP</b>	<ul style="list-style-type: none"> <li>• Ensure all eligible patients receive all appropriate secondary prevention measures especially at Furness General Hospital</li> <li>• Ensure all Acute Coronary Syndrome patients are admitted to the cardiac ward</li> </ul>
<b>National Heart failure database</b>	<ul style="list-style-type: none"> <li>• Ensure inappropriately coded patients are re-coded</li> <li>• Ensure all patients have echo to confirm/exclude diagnosis ideally as an inpatient</li> <li>• Use all appropriate treatments in all eligible patients</li> <li>• Ensure appropriate follow up after discharge</li> <li>• Improve communication with GPs patients and carers especially regarding drugs and monitoring</li> <li>• Ensure heart failure patients are cohorted on a cardiology ward</li> <li>• Entry of data on all heart failure patients onto the database</li> </ul>
<b>Fractured Neck of Femur</b>	<ul style="list-style-type: none"> <li>• Minimise the time patients stay in A&amp;E Department, increased awareness of 36 hour time-frame.</li> </ul>

		<ul style="list-style-type: none"> <li>• Prioritise those patients who are going to theatre</li> <li>• Ensure patients are seen by geriatrician within 72 hours</li> </ul>
<b>Prescribing of Emergency Oxygen</b>		<ul style="list-style-type: none"> <li>• Change to standard prescription chart to record usage in printed type-face</li> <li>• E-learning package for nurse training – implemented</li> <li>• E-learning package for doctor training – implemented</li> <li>• Oxygen Policy to be reviewed and amended to incorporate above changes</li> </ul>
<b>Asthma Audit</b>		<ul style="list-style-type: none"> <li>• Arrange follow-up with GP within a week post-admission and document this.</li> <li>• Arrange new discharge pack to facilitate the above</li> <li>• Check and document device technique prior to discharge</li> <li>• Design a checklist to document inhaler technique</li> <li>• Design information leaflet for all admissions</li> <li>• Check and document PEFR in patients above 5 years of age</li> <li>• Asthma management plan to be given at discharge to all patients, documented in casenotes</li> <li>• New doctors – raise awareness at induction</li> </ul>
<b>Adult Diabetes In-patient Audit</b>		<ul style="list-style-type: none"> <li>• Induction of in-patient diabetes specialist nurse to support inpatient care at RLI</li> <li>• Introduction of 'Think Glucose Programme' to ensure inpatients requiring intervention of diabetes teams are seen at FGH and RLI</li> <li>• Introduction of ward-based education for nursing staff in diabetes care to reduced errors related to insulin and oral diabetes medicine administration</li> <li>• 'Safe Use of Insulin' on-line training module made mandatory for all clinical staff who prescribe and / or administer insulin – application to be made to Trust board</li> <li>• Introduction of Trust-wide foot screening assessments for all patients with diabetes admitted to hospital based on DUK 'Putting Feet First' resources</li> </ul>
<b>Paediatric Diabetes Audit</b>		<ul style="list-style-type: none"> <li>• Improve glycaemic control</li> </ul>

Table 6

Following the CQC visit to the trust in early February 2014, it was highlighted that the Trust would ensure that:

*“All audits identifying performance and practice shortfalls have an action plan developed to ensure improvements and manage and escalate risks”.*

In response, the Trust formulated an Action Plan comprising the factors outlined in the table below, deadlines and responsible persons. Column D demonstrates that all actions and deadlines were met and evidenced (100%).

### Care Quality Commission Recovery Action Plan: Clinical Audit

Action	Target Date	Responsible	Target Achieved
Annual clinical audit plan for 2014/15 to be developed using Healthcare Quality Improvement Partnership (HQIP) Guidance to prioritise audits	21.07.2014	Director of Governance/ Medical Director	Yes
From the 2014/15 annual audit plan, all audits will have an action plan developed in line with Healthcare Quality Improvement Partnership (HQIP) Guidance	31.03.2015	Director of Governance/ Medical Director	Yes
Review and update the Clinical Audit Policy and present to the policy group for ratification	30.09.2014	Director of Governance/ Medical Director	Yes
Implement and utilise a clinical audit module on the Ulysses safeguard system to follow up and monitor the timely implementation of clinical audit action plans	31.12.2014	Director of Governance/ Medical Director	Yes
To establish a Clinical Audit & Effectiveness Steering Group and devise the Terms of Reference to monitor the process of clinical audit implementation	30.09.2014	Director of Governance/ Medical Director	Yes
From the 2014/15 annual audit plan, 80% of audits will have an action plan implemented within the allocated timescales. (Milestones to achieve monitored through Key Performance Indicators)	31.03.2015	Director of Governance/ Medical Director	Yes

Table 7

### **CQC Request: Record-keeping Audit**

Good clinical record-keeping contributes to maximising patient safety and quality of care (through improved completeness of documentation by clinicians, and improved clinical performance). It supports professional best practice and assists with compliance with the relevant national, regional, professional and local clinical record keeping requirements.

One of the recommendations within the Recovery Action Plan was to audit the quality of documentation within our paper health records, clinical case-notes and nursing notes. Indeed, undertaking this form of review is good practice and the trust was keen to comply with this request.

The audit of Record Keeping & Documentation highlighted the learning point of ensuring that information is recorded in all the appropriate sections of health records. Regular monthly audits are planned for all trust specialties, sites and wards during 2015/16 following formulation of the action plan below (Table 8). Auditing and reporting on the quality of our recordkeeping on a monthly basis has now been embedded in the audit workload of each and every specialty across the trust.

The Clinical Audit Department is currently working on an electronic roll-out of the data capture for this project, in conjunction with IT-proficient staff within the Governance Division. Initial discussion have taken place and timescales have been agreed, and the electronic tools can be formatted in a short period of time once all clinicians have trialled and approved the format which will fully satisfy the requirements set out. This work is expected to be completed during the first quarter of the 2015/16 academic year.

#### **Action Plan Devised by Deputy Medical Director**

<b>Action required</b>	<b>Required Date</b>	<b>Person Responsible</b>
Specialty based data received from the Clinical Audit Department to be presented at the next specialty audit meeting	28.2.15	Clinical Directors
Each Specialty must identify the audit tool they will use to undertake a monthly record keeping audit encompassing a random selection including: <ul style="list-style-type: none"><li>• Outpatients</li><li>• Inpatients</li><li>• Discharge Summary</li><li>• Consent forms (where appropriate)</li><li>• Prescription charts</li></ul>	28.2.15	Clinical Directors
Results to be presented at divisional monthly review meetings	31.3.15	Clinical Directors
Results to be presented at Quality Committee	31.3.15	Clinical Directors
Send the results and action plan to the Clinical Audit Department on a monthly basis	31.3.15	Clinical Directors

*Table 8*

## Clinical Audit Improvement Journey



### **Clinical and Non-Clinical Audit Procedure 2014-2017**

This procedure has been developed to provide a framework for consistent implementation and monitoring of clinical audit and non-clinical audit activity across the Trust. It outlines the Trust's commitment for ensuring that all healthcare professionals have the opportunity, skills and support to participate in the clinical audit process and thereby continually improve their practice.

#### **Clinical Audit**

Clinical audit forms an integral part of the clinical governance 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.

#### **Non-Clinical Audit**

Audits provide assurance to the Board that non-clinical procedural documents e.g. health and safety, are adhered to, or they identify potential areas of concern and make recommendations for improvements.

#### **Scope**

The Trust philosophy for clinical audit is to:

- Ensure that audits are relevant and help ensure that the services provided are safe, of a high quality, and meet local, regional and national standards.
- Encourage audit to be utilised to drive and monitor clinical improvement and changes in practice.

### **Clinical Audit Strategy 2014-2016**

The overall aim of this strategy is to improve and embed effective clinical audit across the organisation and in so doing to:

- Support the development and delivery of the Trust's clinical strategy by fostering a culture and discipline of quality improvement in clinical practice, based on reliable, evidence-based assessment of our effectiveness
- Provide robust assurance to internal and external stakeholders on standards of, and continuous improvement in, clinical practice.

## Clinical Audit & Effectiveness Steering Group

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During 2014 the Clinical Audit & Effectiveness Steering Group was established, with the first of its meetings taking place in September. This group is accountable to the Quality Committee for the implementation of the NICE Policy, Clinical Audit Policy and Strategy and for ensuring that the audits listed on the Clinical Audit Forward Programme are completed.

The meetings are chaired by the Medical Director or the Director of Governance and all clinical audit leads are required to attend and participate on a monthly basis.

The overall objectives of the Steering Group are to:

- Facilitate and manage clinical audit and clinical effectiveness across the Trust
- Ensure a framework for safe effective clinical practice is developed and implemented that has a focus on improving patient clinical outcomes
- Provide monitoring of clinical effectiveness through scrutiny of the clinical audit programme and its implementation, including reviews of clinical audit and NICE policies, to support safe effective clinical practice
- Provide a forum to review, discuss and monitor the implementation of relevant NICE guidance

From the outset this group has demonstrated itself to be a robust and effective force for driving forward the implementation of the forward programme of audit topics and, furthermore, has been noted as providing invaluable support to the clinical audit leads.

### **Modified reporting template – monthly**

One of the Clinical Audit & Effectiveness Steering Group's main tasks is the reporting of progress against planned audit activity, this reporting is a standard meeting agenda item. The following template is used to track the progress of every individual project, using a RAG-rating system (Red, Amber and Green). Any project not demonstrating the forecast progress is discussed and actions taken to re-establish momentum.



### Key for Colour-coding of Progress Status

Current status	
<b>Red</b>	Cause for concern. No progress towards completion.
<b>Amber</b>	Delayed, with evidence of actions to get back on track
<b>Green</b>	Progressing on schedule (P), or completed (C) Please indicate with a P or a C
<b>Blue</b>	Audit not planned to start this month
<b>Purple</b>	Await publication of National Results
<b>Black</b>	Audit removed from the audit programme
<b>Grey</b>	No more information needed as completed

AUDIT TOPICS AGREED ON FORWARD AUDIT PROGRAMME																			
Audit title	Priority level	Specialty	Audit Lead	Planned Start date	Planned Completion date	Q1 (Apr-Jun)			Q2 (Jul-Aug)			Q3 (Oct-Dec)			Q4 (Jan-Mar)			Action plan Developed	Full Action plan implemented
						A	M	J	J	A	S	O	N	D	J	F	M		
Compliance with NICE guidelines for imaging DVT	1	Radiology	Dr Sambrook	Sep-15	Dec-15														
Review of breast malignancies picked up by a single reader Breast QA requirements)	1	Radiology	Dr Schofield	Dec-15	Feb-16														
DXA Scanning in Hip Fracture (Reserve topic due to duration)	1	Radiology	Dr R Proctor / E Bell	Apr-15	Mar-16	P													
Nasogastric Tube Imaging	2	Radiology	Dr S Slater	Mar-15	May-15	P													

Table 9

## Closure of Inaugural Year

As the Clinical Audit & Effectiveness Steering Group reporting structure is on a one-month retrospective basis, the April meeting saw summation of the workload of the 2014/15 Forward Audit Programme along with those audits which had been added throughout the year. There were presentations made by auditors whose projects had demonstrated notable improvement.

## Audits for Improvement

- Patients' Perspective of Surgical Ward Rounds: Miss P Patel
- Paediatric Asthma Audit: Dr A Kale
- Acute Kidney Injury: Dr B Obale
- Caesarean Section: A Andrews, Audit Midwife
- Breast Surgery Audit: Mr R Parmeshwar
- Neutropenic Sepsis: Dr S Moon & R Onions
- Anaesthetic Record Keeping Audit: Dr M Kumar

## End of Year Awards & Recognition of Achievement

Awards were presented to clinical audit leads and staff in recognition of achievements made throughout the inaugural year.



### Recognition of Full Compliance with the 2014/15 Forward Audit Programme:

- Miss P Patel
- Mr R Parmeshwar & Ruth Benn
- Dr S Slater
- J Livingstone



### Significant Progress Award

- A Andrews, Audit Midwife

### Clinical Audit Staff Award

- L Kaighan, Clinical Audit Facilitator & Team Leader
- E Stewart, Clinical Audit Educator (Deputy Manager)

### **Continued Streamlining of Processes**

During 2014/15 we carried out extensive works in order to evolve and streamline the processes for registration, monitoring of action plans and progress reporting. This is hugely important in order to try and minimise the burden on audit leads wherever possible and to ensure we comply with requirements and can confidently respond to requests for provision of evidence relating to the safe practice delivered by the Trust.

### **Electronic Format of Audit Proposal Documents**

The Clinical Audit Department has been endeavouring to transfer as many of its procedures as possible into electronic format. One of the most obvious requirements was to have an electronic audit proposal form. To this end we worked closely with the trust's Web and Systems Developer to create the required system. This was achieved in a relatively short period of time and the electronic audit proposal system has been in effective use since December 2014.

On submission of a completed proposal form, the submission is automatically sent to a dedicated Clinical Audit Inbox. The staff members all receive automated notification at the time of submission for prompt processing and approval of topics

### **Clinical Audit Register**

In line with the Clinical Audit Policy (replaced in 2014) and the Clinical Audit Procedure (2014-17) documents, the trust requires that all audit projects are registered with, and approved by, the Clinical Audit Department. This is to ensure that all projects are compliant with The Data Protection Act, Caldicott Guidance and Information Governance protocols, and also to ensure that we are able to receive and report on the findings and action plans from all projects. Therefore, the Clinical Audit Department maintains a robust and up-to-date (on a daily basis) of all projects registered and the progress thereof. During 2014/15 the register was further adapted to facilitate information relating to whether action plans following projects had been received, implemented and completed. This information is required for CQC Recovery Action Plan but its primary importance is for dissemination to clinicians, teams and patients and is a record of the improvements that are made on an ongoing basis within the Trust as a result of reviewing our practices and outcomes via the clinical audit process.

During 2015/16 this system will be replaced with a universal tool utilising the Ulysses system. This system will be a one-stop tool for registration and storage of all audit projects. However, in order to ensure validity and timely reporting, the clinical audit department will maintain an abbreviated version of the clinical audit register. This will run alongside the new system until we are assured of its functionality and reportability.

## Clinical Audit Module within the Safeguard System



For the purposes of clinical incident reporting the Trust employs the Safeguard System, provided by Ulysses. Since May 2014 the Clinical Audit Department have been liaising with the Ulysses team to pioneer a clinical audit module within the Safeguard System, working closely with the Trust's Integrated Risk Team who are much more familiar with the system. Once this module is effective, it can be made available to other trusts wishing to utilise it.

As part of the process, the Ulysses team developed a short-term module to enable the department to capture incoming action plans, track the progress and record and store evidence of completion for all projects undertaken throughout 2014/15. The clinical audit team have been using this temporary action-planning module in order to report on progress for the CQC Key Performance Indicators of 100% of Level 1 and 2 audits to have an action planned devised and for a minimum of 80% of these to have said actions completed within prescribed timescales. The function of the temporary action-planning module will be incorporated within the fully Ulysses Clinical Audit Module from April 2015, with clinicians taking ownership of action plan submission, progress reporting and evidence storage.

The new full Clinical Audit Module will act as an electronic submission system and will replace the current temporary e-form method. In addition, the Ulysses module will act as a management system for approval and registration of projects as well as a communication format for audit proposal submission which require further work until they are fully suitable for approval.

The system will provide a progress status, which will be exportable in to report format, giving instant status information to those staff eligible for receipt. As previously outlined, the Clinical Audit Department will maintain an abbreviated clinical audit register until it is fully confident that the Ulysses system provides the functionality required.

On completion of audit projects, the Ulysses module will store completed presentations, reports, summary data reports and action plans developed based on audit data findings. It will also RAG-rate (Red, Amber, Green) the actual data findings against those pre-defined criteria and standards and report on level of achievement. Further, the module will store and report on the progress status of the action plan completion and will store the required evidence of action plan implementation.

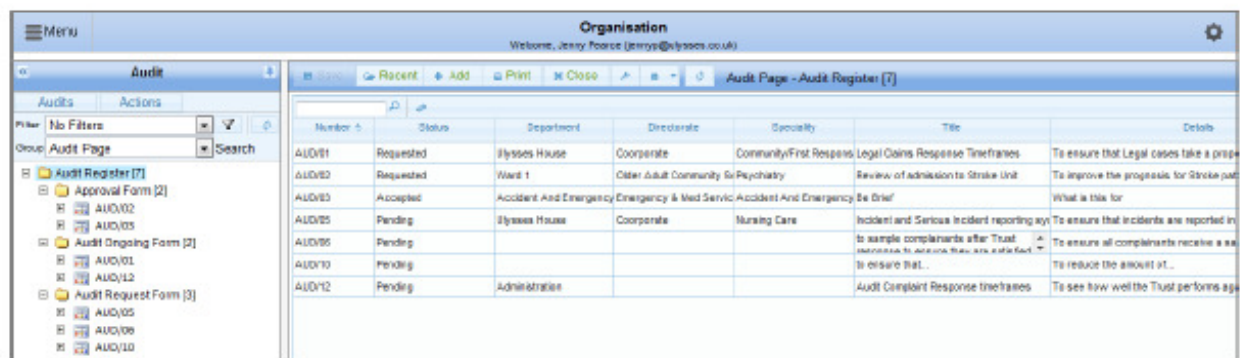
For any projects that are non-compliant with predicted timeframes, eg delayed commencement, delayed completion, delayed action plan submission, the module will send automated reminders to relevant clinical staff to prompt appropriate actions.

For those long-serving clinical audit staff this is a hugely exciting prospect. The system is very adaptable and it will be possible to configure it to entirely meet our needs, eg format of data fields, names of data fields, etc. It is anticipated that the module will eliminate a large amount of manual data recording and updating and that the electronic factor will be welcomed by the clinical teams as a modern, streamlined tool which will increase their efficiency when undertaking audit projects.

The clinical audit team were trained on system usage in November 2014. Further work has been undertaken by the Ulysses team following consultation and feedback sessions. Final amendments have been made and the module will have a short trial period in May 2015.

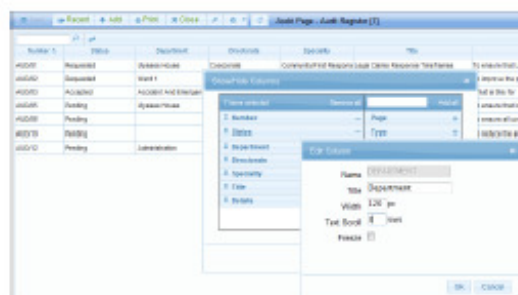
In preparation for the implementation, the module was introduced to the clinical audit leads; Director of Governance and Medical Director at the Clinical Audit and Effectiveness Steering Group on 30 April 2014. All audits registered from 1 April 2015 will be included to ensure comprehensive reporting for the next academic year. Once the system is fully operational the clinical audit team will provide training and support to auditing clinicians to ensure maximised benefit from the system.

#### Audit List:



Number	Status	Department	Directorate	Speciality	Title	Details
AUD/01	Requested	Ulysses House	Corporate	Community/First Response	Legal Claims Response Timeframes	To ensure that Legal cases take a proper...
AUD/02	Requested	Ward 1	Older Adult Community & Psychiatry		Review of admission to Stroke Unit	To improve the progress for Stroke pat...
AUD/03	Accepted	Accident And Emergency	Emergency & Med Service	Accident And Emergency	Be Brief	What is this for
AUD/05	Pending	Ulysses House	Corporate	Nursing Care	Incident and Serious Incident reporting system	To ensure that incidents are reported in...
AUD/06	Pending				To sample complainants after Trust	To ensure all complainants receive a sat...
AUD/10	Pending				To ensure that...	To reduce the amount of...
AUD/12	Pending	Administration			Audit Complaint Response timeframes	To see how well the Trust performs ag...

The List can be configured, select different fields:



## Staff Commitment and Involvement

The clinical audit facilitators will continue with their personal development plans, these include attendance at all relevant Trust training sessions (in addition to those that are mandated) and will avail themselves of any further opportunities that are both cost-effective and relevant to the Trust

requirement. In order to be apprised of developments in the national clinical audit area, staff are keen to attend any events provided by Healthcare Quality Improvement Partnership (HQIP).

In November 2014, HQIP organised and funded a training session entitled “Clinical Audit Circuit Training”. The event was interactive and attendees were expected to participate in the workshops. This session was fully funded by HQIP and our Trust was fortunate enough to secure places for the maximum 3 attendees permitted, ensuring attendance from both trust sites. Our attendees found the session extremely beneficial and provided detailed feedback to the others in the team.

In January 2015 the two department Team Leaders attended an HQIP-funded 1-day workshop on Undertaking Root Cause Analysis. The event was compiled and delivered by the Clinical Audit Support Centre, an independent body of experienced clinical auditors.

### **Staff meetings**

Although we are one department, the two trust sites are a notable distance apart and it can be difficult to work in the most effective way with this complication. Therefore the department will endeavour to facilitate monthly team meetings during 2015/16 with the aim of increasing cohesion. All staff is currently encouraged to make suggestions for improvements and streamlining of processes and reduction of duplication on an ad hoc basis but by scheduling regular meetings we will give ourselves scope and time to maximise any suggestions carried forward.

### **Team briefs**

As part of its ongoing drive to improve two-way communication with all levels of staff “from Board to ward”, the trust have implemented monthly Team Brief meetings. These meetings require the mandatory attendance of a member of staff to hear the brief from one of our executive colleagues. Attendees are then required to disseminate the information within their teams within one working week of receipt.

Senior members of the clinical audit team have received the trust’s training on effective dissemination and Team Brief dates are entered into electronic calendars for all foreseeable dates.

### **Appraisals**

All clinical audit staff received full and detailed appraisals within the timescales set out by the trust. The department undertakes this fully and is extremely keen to support staff with any training they feel they may require or which is highlighted through the appraisal process.

The appraisal process is taken seriously by the department and the appraisal process is undertaken fully. Appraisal sessions are pre-booked and mutual times agreed for the meetings

themselves. This allows fully adequate time for pre-planning to be undertaken by appraisers and appraisees.

The trust has a comprehensive portfolio of training opportunities which are supplied 'in-house' and the department is keen to avail the staff of all, any, opportunities. The department is also a keen participant in any of the HQIP training sessions regularly available and which are usually free of charge.

### **CQC Mock Inspections**

In preparation for CQC's return visit the trust has been undertaking regular mock inspections on all of its sites. These have been designed as an opportunity to use a "fresh eyes" approach to all areas of our sites and it has been agreed that this is something that will remain in place in the future as a marker of good practice.

All levels of staff are invited and encouraged to participate where they can and the audit department have been involved also. The Head of Clinical Audit and Effectiveness and the Clinical Audit Educator (Deputy Manager) have both participated. In addition, other members of the team have enrolled to participate at future inspections.

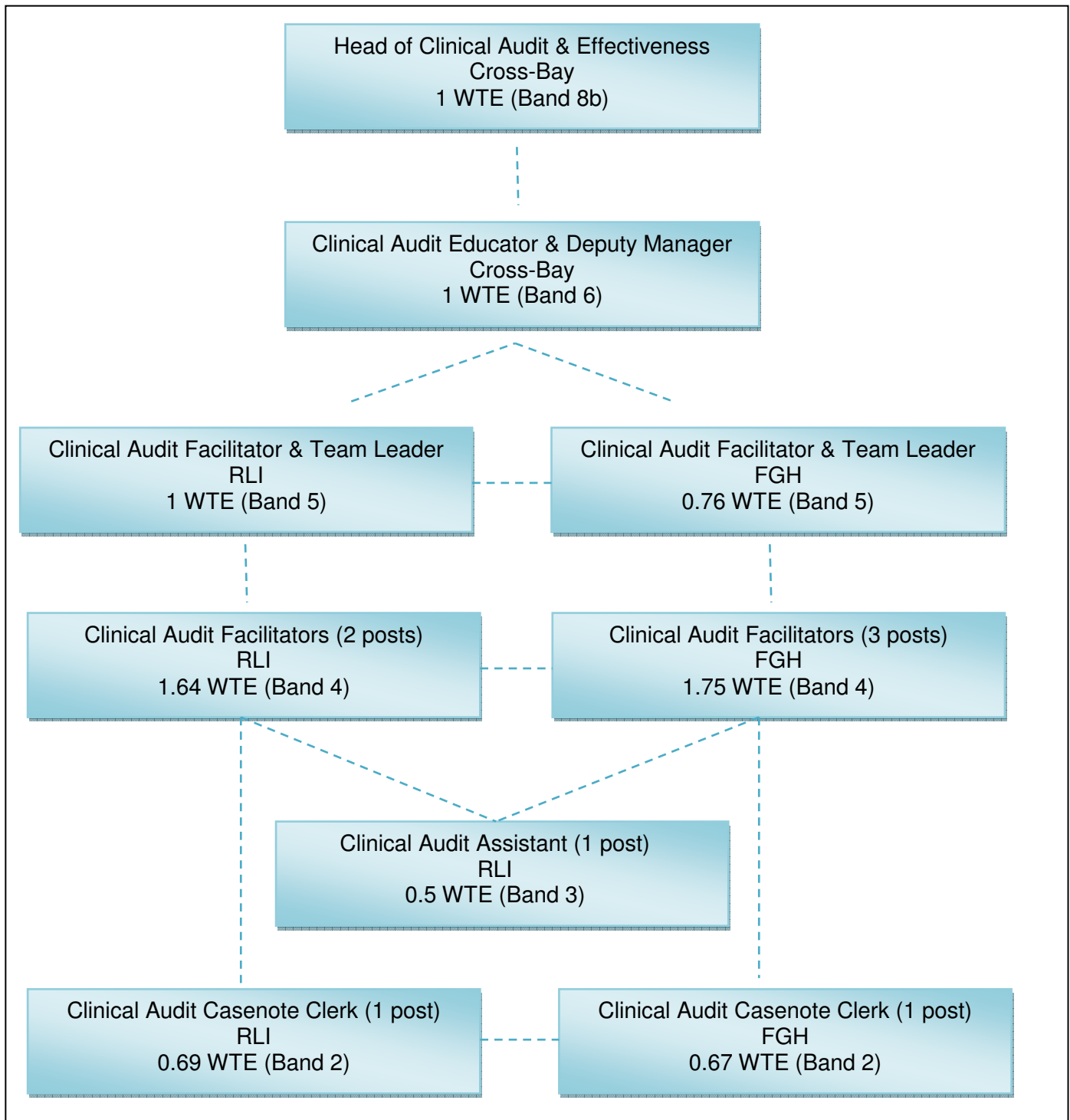
### **Leadership Conference**

The Head of Clinical Audit and Effectiveness and the Clinical Audit Educator (Deputy Manager) attended the Leadership Conference in September 2014. The session was informative and it was decided by attendees that another similar session was required. Accordingly they both attended the subsequent session in March 2015, this time along with one of the Team Leaders. This session was designed to be more interactive (based on feedback from the previous meeting) and the clinical audit staff participated fully in the event, feeding back relevant information to the remainder of the team.

The staff will attend and participate at the next session, date yet to be announced.

### **Listening into Action**

As part of its improvement drive the trust is endeavouring to give opportunities to staff to have a voice and to be heard. One of the initiatives around this was the set of sessions entitled "Big Conversations". Across the trust there were several opportunities on each site in which staff could attend and engage. The clinical audit staff at the Furness General Hospital site each independently registered their interest and gained places. It was a thoroughly enjoyable session and all staff participated and had ideas which they felt they could contribute. No idea was too large or too small and all were taken by the Listening into Action Team for further consideration. It is pleasing to note that within a very short period of time some of the simpler "Quick Wins" were evidently being activated.





### **Departmental Restructure**

On the advice of the Director of Governance the department underwent a moderate restructure. New roles of Clinical Audit Educator (Deputy Manager) and 2 Team Leader posts were created. It was felt that due to the raised profile of the department and commensurate degree of pressure, due to workload and the requirement for provision of assurance and evidence of improvements in practice, outcomes and patient experience that a supportive leadership tree was required and that the previous format was inadequate. The Clinical Audit Educator (Deputy Manager) post was effective from 1 April 2014, with the Team Leader posts coming into force in October 2014.

It must be noted that the department achieved this at no extra cost to the trust. No additional finances were received, indeed the department still managed to achieve their designated Cost Improvement Programme defined savings. The posts were achieved by absorbing the role of a 0.8 WTE post following the retirement of a team member.

### **Recruitment of Staff Members**

The Clinical Audit Educator (Deputy Manager) post was filled by an experienced clinical audit facilitator from within the audit team. Whilst undertaking the new role, the Deputy Manager simultaneously fulfilled the previous role until the appointment of the replacement. We welcomed Catherine Townend to the audit department in October 2014 and she is settling into her new role extremely well.

We also had occasion to see another clinical audit facilitator leave the department on returning to a nursing role. We recruited for a replacement facilitator to take responsibility for the Sentinel Stroke National Audit Programme data collection and submission. Therefore, we were very happy to welcome John Wilson to the department in December 2014 and are happy to say he, too, is settling into his role and into the department extremely well.

## Clinical Audit Intranet Site

The intranet pages of the Governance division have been revised and reformatted. The clinical audit department are extremely pleased with their new intranet site. It is now much more contemporary and streamlined with much improved navigability.

The screenshot displays the Clinical Audit Intranet Site. At the top right, the breadcrumb trail reads: UHMB > Departments > Governance Division > Clinical Audit. The main header is 'Clinical Audit'. On the left is a vertical navigation menu with categories: Governance Home, What Is Governance?, Audit, Advancing Quality, Clinical Audit Resources, NICE Guidance, Guidelines & Policies, Heritage, Learning To Improve, Health & Safety, Risk Assessments, Resources, Training, COSHH Inventory, Security, Library & Knowledge, Patient Relations, Risk & Incidents, Resources, Legal Services, Corporate Governance, Programme Management Office, Compliance & Assurance, External Agency Visits, Quality & Safety Walkabouts, and Meeting Calendar. The main content area is divided into sections. 'Common Tasks' includes 'Audit Forward Programme' (describing the forward programme), 'Propose An Audit' (linking to an online proposal form), and 'Audit Resources' (linking to planning materials). 'Steering Group Workspace' links to meeting materials. 'What is Clinical Audit?' defines the process and lists training topics like audit design, spreadsheet design, data presentation, and action plans. 'General Resources' is a table of documents.

Type	Name	Description	Modified
Document	Audit Facilitators and Assistants (Divisional Allocation)		21/04/2015 14:24
Document	Clinical Audit Annual Report 2013-14		21/04/2015 10:38
Document	Clinical Audit Forward Programme 2015-16		21/04/2015 10:35
Document	Clinical Audit Strategy 2014-2016		21/04/2015 10:37

Below the table is an 'Add document' link. Further down is a section for 'HQIP (Healthcare Quality Improvement P...)' with a red 'HQIP' button and a description of the charity's aims.

The clinical audit area of the website contains a link to the current Forward Audit Programme, along with a link to the electronic proposal form, allowing all staff access to selection and submission of projects at a time that is convenient to them.

In addition, there is access to all of the clinical audit information guides which we have produced and the contact details of all staff within the department.

This year, we have been able to introduce an electronic “work space” for the Clinical Audit & Effectiveness Steering Committee. This will allow all papers and documents required for the meeting to be placed within the workspace, enabling committee members to freely access required materials. This will streamline the meeting preparation process and eliminate the need to send out emails with multiple, bulky, attachments.

We have also included a hyperlink which directs trust staff to the HQIP website where they can find the most current information released, enabling them to have direct access to the issues currently disseminating from the Department of Health and NHS England.

## Maternity Services & Obstetrics: Continued Progress

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In 2013-14 the trust created the new role of Clinical Audit Midwife. The function of this role is to facilitate and support clinicians and practitioners working on the extensive Maternity audit portfolio.

Following the appointment the Clinical Audit Department worked closely with, and acted as a mentor for, the appointee and the department is proud of the achievements that have been made in this inaugural year.

The initial appointee retired in June 2014. As part of the hand-over process, the new appointee, Amanda Andrews, “shadowed” the departing clinical audit midwife, once more working very closely with the clinical audit department. This proved a very effective process and we are delighted that the clinical audit midwife is now fully assimilated to her new role, showing marked dynamism and passion for the audit process and the changes it can bring.

The audit midwife has attended every one of the Clinical Audit & Effectiveness Steering Group meetings since its inauguration, reporting the progress status of ongoing and completed audits and, in addition, action plans and their implementation status. She has found she has benefitted from the support received by the committee. The Clinical Audit Department has fully supported her and she is now fully self-sufficient with the continuous audit projects and meets regularly with the department to discuss audits due for commencement.

The Clinical Audit Department would like to acknowledge these efforts and thank the Clinical Audit Midwife for all her efforts and dedication to the role.

## Northwest Regional Clinical Audit Network

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The Cumbria and Lancashire Clinical Audit Network (CALCAN) was established in May 2010. Coverage ranges from North Cumbria Acute Trust to Southport & Ormskirk and over to Blackburn. Membership comprises of acute Trust, mental health Trust, ambulance services and NICE. The networks were initiated, and are supported by, HQIP in a concerted effort to promote the sharing of knowledge and good practice within audit departments and to provide a framework of self-support to audit teams within each network.

CALCAN was one of the first networks in the Northwest Region and our RLI site was the venue for the inaugural meeting. It is very pleasing to note that the visiting members have elected the RLI site as the permanent venue. The network meets on a quarterly basis, is thriving and proving to be a valuable resource. There is frequent attendance by an HQIP representative and a regular attendance from a representative from NICE. In addition, there are external speakers, for example representatives from NCEPOD, CQC and NHSLA.

## Healthcare Quality Improvement Partnership

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### History

The Healthcare Quality Improvement Partnership (HQIP) was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales. HQIP is led by a consortium comprising the following organisations:



HQIP support, advise and train clinical audit professionals and have developed, in collaboration with clinical audit departments many professional tools and materials to assist in the audit processes. The template for this report is one example. The Trust's Clinical Audit Department participated in this at HQIP's inception. HQIP also provide high-quality, inexpensive (often free of charge) workshops, training sessions and conferences and have been hugely supportive of the clinical audit department in UHMBFT.

Our department has an excellent relationship with HQIP and their representatives have visited Trust staff on several occasions, collaborating with us in order to provide training to clinical audit specialty leads. They also fund, support and attend our North West Regional Audit Network meetings.

## Highlighting the Audit Process: The HQIP 'Teabreak'



The Clinical Audit Department was amongst those who participated in the second of HQIP's Clinical Audit Awareness Weeks during 2014. We ran roadshow events in the dining room of each of our Royal Lancaster Infirmary and Furness General Hospital sites using a display boards, with the audit team in attendance. We displayed examples of audits carried out within the Trust which have improved procedures and impacted on patient care, one example of which is the "Neutropenic Sepsis Audit & Re-audits" which demonstrate ongoing improvements in outcomes. The team actively engaged with members of staff, patients and visitors in discussion and invitations to complete an informal quiz and word searches, with a small prize for the lucky winner who was drawn at random.





Clinical audit is one of the main components of quality improvement and governance, and a central mechanism for reviewing clinical practice against existing standards, guidelines, policies and procedures.

Following the findings of the inquiries into the events at Mid-Staffordshire hospital, there needs to be increased scrutiny of quality of care delivered at all levels, both internally, from ward to Board and also externally, by commissioners and regulators, including CQC. Warning signs which were missed at Mid-Staffordshire included information provided in auditors' reports around the accuracy and reliability of compliance with standards and the collation of valuable data from varying sources such as risk, complaints, finance, performance and human resources. One of the criticisms in the Francis Report was the lack of focus on clinical audit and little evidence of ownership or accountability within the organisation.

Trusts are mandated to include their programme of clinical audit, with findings and actions, in their annual Quality Account. The need for full and accurate information on compliance (or non-compliance) with fundamental and enhanced standards is a key recommendation from the Francis Report. Also, Monitor's Model Annual Governance Statement cites clinical audit as a key indicator for Accounting Officers reviewing the effectiveness of internal systems of control.

It is therefore vital for organisations to ensure that appropriate assurances from Clinical Audit are gained and accurately reported both within the organisation and to external agencies.

During the year, 'Internal audit' undertook an audit to provide assurance on the Trust's ability to demonstrate the value realised as a result of carrying out clinical audit. We are waiting for the final assurance rating.

### Audit of Clinical and Non-clinical Audit Procedure

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#### **Executive summary**

An annual audit of the Trust's procedure on clinical audit is required as part of our governance arrangements. The aim is to ensure that our systems and processes in relation to clinical audit are robust and to identify specific areas where action may be required. The requirements of NHSLA were extended, mandating that all NHS organisations undertake an annual audit of their clinical audit process to provide assurance that all clinical audits are undertaken, completed and reported

on in a systematic manner. This audit reflects whether audits are conducted in line with the approved process for audit.

Please note that a MIAA Internal Audit Review of the systems and processes in place with regards to Clinical Audit (undertaken December 2014) we are awaiting assurance level in respect of the robustness of the systems in place for clinical audit. This audit is supplementary to the MIAA review and in light of the findings from this audit and when we receive the MIAA review, it is proposed to develop a single action plan to support the further development of clinical audit.

### **Background/Rationale**

All NHS organisations are required to have in place a comprehensive programme of quality improvement activities that includes clinical staff participating fully in clinical audit. As a tool to stimulate quality improvement activities, clinical audit can demonstrate that real efforts are being made to deliver high quality professional care. Whilst there are a variety of related processes which have a role in measuring and improving quality (such as significant event enquiries, patient surveys, research, adverse event analysis, peer review and internal audit) none of these are a substitute for robust clinical audit in terms of assessing standards of clinical care against national, regional or local standards/guidelines. For individual practitioners, involvement in audit is an integral component of good clinical practice and as part of wider healthcare regulatory requirements we must be able to evidence that we have comprehensive programmes of audit in place which lead to demonstrable improvements in care.

The overall aim of the audit of clinical and non-clinical audit procedure is to establish a common framework across the Trust to ensure that our audit activity follows best practice guidance and that the value of audit projects is realised within the clinical assurance process and in terms of the improvements arising as result of clinical audit outcomes.

An annual audit of the Trust's procedure on clinical audit is required as part of our wider governance and assurance arrangements. The audit is designed to ensure that our systems and processes in relation to clinical audit are robust and to identify specific areas where action may be required.

### **Aims/Objectives**

To provide assurance that the clinical audit processes in place are robust and fit for purpose. To audit individual audit projects against the Trust wide approved process for audit.

### **Standards/Guidelines/Evidence Base**

Audit of UHMBT Clinical and Non-clinical Audit Procedure, specifically focusing on

- whether audits are conducted in line with the approved process for audit
- how the organisation makes improvements

## **Data & Methodology**

An audit topic from each specialty of clinical audit projects were selected from the total number of audit projects on the audit register/database from April 2014 to March 2015 (n=23).

## **Caveats**

Clearly, we can only audit those projects which are known and registered with the clinical audit department. A number of trusts across the NHS (particularly those which are large and/or cover a large geographical area) have raised concerns that not all audit projects may be registered / recorded centrally and that audit activity is undertaken outside of the approved process. Within our trust the Clinical Audit Team has, over the past 2 years, worked extensively with the Clinical Audit Leads for each speciality to ensure that audit activity is brought under a common process and we are confident that an extremely high proportion of audit is registered.

As with any sampling framework, the sample selected may not be representative of the wider total population. A sample was selected as it was felt that this would give a reasonable overview as to the processes in place. Whilst not statistically significant, the results will enable the audit process to be tracked and each speciality had an equal chance of inclusion.

## **Findings**

Table 10 below provides more detail as to the 16 individual elements which comprise the process for speciality audit projects across our trust. Whether at individual project level or specific element level, the audit identifies some high levels of compliance with the agreed audit process.

## **Discussion**

The findings from the audit identify the need to enhance the systems and processes in place for making sure that every audit has a completed audit proposal form and receiving audit summary reports / audit presentations within the Divisions/specialties.

A new strategy and procedure have been ratified and implemented and the clinical audit team, clinical audit leads and clinical audit and effectiveness steering group have been working to develop the quality of audit across the trust. There is little point monitoring an audit which is of poor quality. The focus of attention over the past 2 years has therefore been to ensure that audits are of a high quality and that the broad infrastructure for topic selection and project design are sound. Staff across all specialities undertake audit projects and the profile and quality of audit has been raised significantly.



## Audit of clinical audit projects for each specialty

Division	Core Clinical Services						Medicine (Elective & Acute)			Surgery and Critical Care								WACS				Corporate/nursing		
Audit number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	
Specialty	Blood	Diet	Pharm	OT/Phy	Path	Rad	A&E	Acute	Elec	Anae	Breast	ENT	Surg	Max	Oph	Orth	Uro	Safe Guard	Obs	Gyn	Paed	Nur	Clin skills	%
1) Proposal form	N	Y	N	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	74
2) Indication if topic on forward audit programme	N/A	N/A	N/A	N	N/A	N/A	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y	88
3) Reason for audit (priority level)	N/A	N/A	N/A	Y	N/A	N/A	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y	94
4) Site	N/A	N/A	N/A	Y	N/A	N/A	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y	94
5) Guidelines listed	N/A	N/A	N/A	Y	N/A	N/A	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y	94
6) Aim/impact on care	N/A	N/A	N/A	Y	N/A	N/A	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y	100
7) Detailed Standards	N/A	N/A	N/A	Y	N/A	N/A	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y	100
8) Audit type	N/A	N/A	N/A	Y	N/A	N/A	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y	100
9) Timescales	N/A	N/A	N/A	Y	N/A	N/A	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y	100
10) CAL Approved	N/A	N/A	N/A	Y	N/A	N/A	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	Y	Y	Y	Y	Y	100
11) Electronic Folder Set Up	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100
12) Project Logged On register	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100
13) Copy of audit presentation	Y	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	Y	Y	N	Y	N	74
14) Summary report sheet	N	N	N	Y	N	N	N	Y	Y	Y	N	N	Y	Y	Y	Y	Y	N	Y	N	Y	N	N	48
15) Action plan developed	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	96
16) Evidence of action plan implemented within allocated timescales	Y	Y	Y	Not due yet	Not due yet	Not yet due	Not yet due	Y	Not due yet	Not due yet	Y	N/A	Not due yet	Not due yet	Y	Y	Y	Y	Y	Not due yet	Not due yet	Y	Y	100
Total %	71	71	71	87	67	57	87	100	100	100	94	67	100	93	100	100	86	57	100	93	93	93	88	

Table 10

### Background

The National Institute of Health and Care Excellence's (NICE) role is to improve outcomes for people using the NHS and other public health and social care services. They try to achieve this by:

- Producing evidence-based guidance and advice for health, public health and social care practitioners
- Developing quality standards and performance metrics for those providing and commissioning health, public health and social care services;
- Providing a range of information services for commissioners, practitioners and managers across the spectrum of health and social care.

Since 1999 they have provided the NHS, and those who rely on it for their care, with an increasing range of advice on effective, good value healthcare. In April 2013 NICE gained new responsibilities for providing guidance for those working in social care.

### Challenges faced during 2014-15

The increasing amount of guidelines that NICE publish was a challenge to coordinate during the past 12 months. In addition, NICE continue to extend their remit and produce new types of guidance; e.g. Medical Technologies Guidance etc., all of which require a new internal process to support implementation or adoption. NICE's remit continues to expand, but the clinical audit department's resources and capacity to manage this remains the same.

It remains a challenge to have a clear picture about where the gaps in data lie and how they might be addressed for the quality standards published. This is due in part to the volume and rate at which quality standards are produced. Having this trust wide overview of all quality standards will be one of the key objectives for the NICE Guidance Coordinator if approved.

### Resources / Support

The clinical audit department has increased the scope of its function over the last 18 months. Besides delivering an increasing clinical audit agenda, the department also encompasses NICE implementation and Advancing Quality. Events over the last few months have highlighted the need for increased amounts of clinical audit; NICE implementation and Advancing Quality are essential to assuring the Trust that it is delivering quality care and meeting CQUIN targets. The projected volume of work will further add to the workload of the clinical audit department. Extra resources are required to ensure the success and timely delivery of NICE implementation.

## **NICE managed through Project Management Office (PMO)**

The project will deliver a process to ensure that all NICE guidance is appropriately reviewed and plans implemented to ensure compliance where appropriate, which is embedded as standard practice across the organisation. It will also deliver a plan to catch up on all outstanding reviews of NICE publications and associated action plans.

### **Aim**

We aim to put in place a process to ensure that all NICE publications is appropriately reviewed and plans implemented to ensure compliance where appropriate, which is embedded as standard practice across the organisation. We also aim to catch up on all outstanding or overdue reviews of NICE publications and associated action plans. Finally, a process for implementation, where appropriate of the NICE Quality Standards will be delivered

### **Confirmation of resource requirements**

Initial baselining has suggested that the Trust does not resource the NICE process at the same level compared to other Trusts. Additional resource is required in the form of someone to coordinate the process and provide support and expertise, noting that implementation is the responsibility of divisions. This gap in resource is apparent where guidance crosses divisions and organisations/stakeholders and requires actions and input across organisational boundaries. This is currently being quantified and will be identified in the Executive Director Group report. If not approved, this would impact on what can be achieved and the timescale.

## **Clinical Audit Meetings and Mortality Review**

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### **Clinical Governance Pack**

During the latter part of 2014, the Lead for Governance liaised with the Head of Clinical Audit and Effectiveness to standardise the Specialty Clinical Audit Meetings held by all specialties across the trust. The purpose of these meetings is to foster a climate in which all healthcare professionals across the Trust collaborate in maintaining the highest quality of healthcare possible through a shared approach to clinical audit and effectiveness processes. This will be facilitated through a proactive approach to all audit activities.

Further, it is aimed to promote the continuing development of a culture of working to standards and encouraging clinicians to regularly review the quality of care they provide.

To this effect, a suite of documents was produced which would facilitate consistency of format, content and reporting of all meetings irrespective of specialty type or location and to maximise the opportunities to learn from colleagues and to share information,

The following templates were devised and distributed during December 2014:

- Terms of Reference for Specialty Clinical Audit Meetings
- Role Specification for Specialty Clinical Audit Leads
- Clinical Audit Forward Programme for the current year
- Details of all clinical audit facilitators – detailing specialties and sites
- UHMBFT electronic clinical audit presentation template
- Specialty Clinical Audit Meeting Agenda template, to include:
  - Mortality & Morbidity
  - Lessons Learned
  - Guidance Review
  - Governance
- Divisional Progress Report template
- Matters Arising Tracker template
- Attendance register template
- Attendance monitoring sheet template
- Audit minutes template

## Education and training

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### Induction

The Clinical Audit team participated in the 'Market Stall' event which was held on each site on doctors' induction days in August and February. During these sessions each in-coming clinician is made aware of the clinical audit department and its role within the Trust. At these events, all discussion is individually tailored to fit the specialty to which the doctor is attached and all audit meetings and any available topics are highlighted at this time. This is a useful opportunity to inform new members of staff about clinical audit and the training and support that is available to them.

### One-to-one training

In addition to the above events, the Clinical Audit Facilitators work closely with all grades of staff across all specialisms. They deliver one-to-one training, support and advice on a daily and ad hoc basis. Each project is individual, even if it's a repeat project, and staff remain adaptable and available to provide the support necessary as it is required.

## Specialty Clinical Audit Leads

Even though the clinical audit team can provide technical expertise, advice and support, the delivery of successful audits which result in better care for patients needs strong clinical leadership as well. Leadership is critical to the success of most things. Clinical audit is no different. This year has seen us more explicitly define the role of a speciality clinical audit lead. The role is recognised as additional responsibility which should be reflected in their job plan.

The aims of a clinical audit lead are to:

- Champion audit within their specialty  
Adopt a systematic approach to developing a clinical audit programme for their specialty that addresses important areas of National and local concern including risks and serious untoward incidents
- Encourage colleagues to participate in appropriate audits and undertake formulation of action plans
- Ensure that improvement in patient care and services occurs as a result of clinical audit.

We developed 3 training sessions in conjunction with HQIP, which was designed to empower and support specialty audit leads to fulfil the role and to see audit more effectively used within their service.

## Learning Lessons

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Learning is part of life and key to improving our services and our working lives. No one can claim they know everything about their job's impact or its effectiveness. We pick things up from so many sources including our colleagues and routinely incorporate good ideas into our work. It's not about being formal or academic; it's about sharing our experiences and making sure we keep getting better. We can learn from audit and mortality and this is picked up in the audit report summary sheet "learning points".

During 2014/15 the Trust established the Complaints, Litigation, Incident and PALS Management Group (CLIP Group). The group meets monthly and is accountable to the Trust Quality Committee, through the Director of Governance and the Non-Executive Director Group chairperson.

The CLIP Group is authorised by the Quality Committee to seek clarification and further investigation of any patient safety and experience related matter, and to request any relevant information from any employee. It is also authorised to obtain outside or other independent professional advice with relevant experience and expertise if required. The group will oversee and

collate divisional lessons learnt communications and monitor and escalate trends and themes arising from divisions

The objectives of the CLIP Group are:

- to focus on Trust-wide, strategic issues for patient and carers
- to monitor, collate and cascade lessons learnt from complaints, litigation, incidents and PALs.
- to ensure systems are in place to report and respond to serious failures and learn from incidents and near-misses.
- contribute to best practice and share good practice with effective communication to underpin the improvement cycle
- to report to and advise the Quality Committee

In particular, the Clip Group will coordinate work being undertaken to improve patient experience across UHMBFT and will regularly review systems and processes, from ward to board in relation to how patient experience issues are managed, to include reports to and from divisions and the Board to ensure congruence and robust reporting. In addition, the group will give consideration to how patient experience intelligence can be used to improve service delivery and will identify where good practice exists, and how good practice for delivering those standards is shared and what helps or hinders its adoption.

The group will receive monthly themed reports from divisions in relation to patient safety and experience and also receive a themed corporate report from Governance Department in relation to incidents and patient safety.

The group will monitor action plans in relation to patient safety and experience and will escalate any area of concern, non-compliance or reported exception to the Quality Committee on a monthly basis.

## **Links with other organisations**

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### **National Institute of Health and Clinical Excellence (NICE)**

NICE produces guidance on public health, health technologies, clinical practice and medical devices. Its role is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current 'best practice'.

At our Trust we are committed to treating NICE guidance as high priority and are working towards compliance with National Guidance, such as NICE clinical guidelines, NICE interventional procedures and NICE technology appraisals. This has prompted the need to develop robust

mechanisms to report, discuss and monitor compliance. This system will ensure in the future that the optimum in patient care, in its entirety, remains at the forefront of the organisations involved in the health and well-being of patients.

### **Commissioning for Quality and Innovation (CQUIN)**

The CQUIN framework makes a proportion of providers' income conditional on quality and innovation. Its aim is to support the vision set out in High quality care for all of an NHS where quality is the organising principle (Institute for Innovation & Improvement). In 2013/14 the clinical audit department has assisted the Trust in developing mechanisms on how best to collect and report data required to support this for the Advancing Quality Regional CQUIN.

### **Advancing Quality - AQuA**

Advancing Quality is an established and proven approach to reducing variation and improving outcomes. It is the flagship programme of AQuA. It aims to give patients a better experience of the NHS by ensuring the highest standards are consistently delivered.

Focusing on clinical focus areas (CFAs) which affect many patients – heart attack, heart bypass surgery, heart failure, hip and knee replacement surgery, pneumonia, stroke, dementia and first episode psychosis – Advancing Quality (AQ) works with clinicians and managers to define and measure good clinical practice .

These standardised quality measures are the basis of the AQ programme, which has been running in the North West since 2008.

AQ aims to:

- Save lives and improve quality of life for patients.
- Drive commissioning for quality in a changing landscape.
- Incentivise and accelerate change.
- Achieve value for money.

Morecambe Bay participates in 5 of the 8 clinical focus areas: Heart Failure, Heart Attack, Hip and Knee Replacement Surgery, Pneumonia and Stroke.

### Heart Attack (Acute Myocardial Infarction)

AMI was launched in 2008 and Morecambe Bay has participated since the launch of this CFA.

- With the exception of Y6 (where three new clinical process measures were introduced) the percentage of AQ AMI patients receiving appropriate care has increased year on year.
- Morecambe Bay has climbed from ranked 16<sup>th</sup> to 7<sup>th</sup> out of 22 trusts in North West AQ Year 1 to AQ Year 6 for patients receiving ACS.

- The number of patients' receiving ACS in AQ AMI has increased by 85% (from 268 to 496) while the AQ AMI population has only increased by 49%, proportionally more patients are receiving appropriate care in AMI.

### Heart Failure

Heart Failure was launched in 2008 and Morecambe Bay has participated since the launch of this CFA.

- Morecambe bay have improved its ranking of participating trusts to 11<sup>th</sup> from 17<sup>th</sup> place of 22 participating trusts for the percentage of AQ HF patients receiving ACS.
- The percentage increase in patients receiving appropriate care is the highest in AQ HF between Y1 and Y6 the percentage of patients receiving all eligible measures has increased by 64%.
- Performance has notably improved since AQ Y4 climbing from 8.5% ACS to 72% in Y6.

### Hip and Knee replacement Surgery

Hip and Knee surgery was introduced in 2008 and Morecambe Bay has participated since the launch of this CFA.

- The number of AQ Hip and Knee patients receiving appropriate care has increased by 46% between Y1 and Y6 (775 patients to 1132).
- Morecambe Bay's performance in this CFA has improved year on year from AQ Y4.

### Pneumonia

Pneumonia was introduced in 2008 and Morecambe Bay has participated since the launch of this CFA.

- The number of AQ Pneumonia patients receiving appropriate care has increased by 64.7% between Y1 and Y6 (232 patients to 382).
- Morecambe Bay's performance in this CFA has improved year on year from AQ Y4.

### Stroke

Stroke was introduced in 2010 and was reported from AQ Year 4 i.e. April 2011. Morecambe Bay has participated since the launch of this CFA.

- Morecambe Bay has turned performance around since the launch of this CFA climbing from bottom of the ranking of 21 trusts in AQ Y4 to 4<sup>th</sup> place in Y6.
- AQ Stroke patients receiving appropriate care in Morecambe Bay have quadrupled between Y4 and Y6 despite the population remaining static.
- Morecambe Bay's performance in this CFA has increased year on year.



### New Clinical Focus Areas

Over the next few months AQ will have launched six new CFAs; Acute Kidney Injury, Alcohol Related Liver Disease, Chronic Obstructive Pulmonary Disease, Diabetes, Hip Fracture and Sepsis. Morecambe Bay is participating in five of these new clinical focus areas and the results for two of them are already in for the first live month of discharges (December Discharges).

When a new CFA is introduced all trusts are set the target of providing appropriate care to one in two patients i.e. their ACS target is 50%. Performance targets are set at this level as Trusts will require a certain level of bedding in of the new CFAs and ensuring data collection processes are capturing all required information.

### **Clinical Audit Leads on our Trust Sites 2014/15**

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The audit lead for each specialty within the Trust is as follows:

<b>Specialty</b>	<b>FGH</b>	<b>RLI</b>
<b>A &amp; E</b>	Miss F MacMillan	Dr S McBride
<b>Anaesthetics</b>	Dr A Szymczakowski	Dr C Rimmer
<b>ENT</b>	Mr M Mian	
<b>Medicine</b>	Dr A Barton / Dr F Wood	Dr L Ottewell
<b>Maxillofacial</b>	Mr D Fisher	
<b>Microbiology</b>	Dr M Pasztor	
<b>Histopathology</b>	Dr M Atwan	
<b>Obstetrics &amp; Gynaecology</b>	Mr S Sinha	Dr N Shantha
<b>Ophthalmology / Orthoptic</b>	Dr R Ajit Paula Harman	
<b>Orthopaedic</b>	Mr V Kamalanathan	Mr T Millar
<b>Paediatrics</b>	Dr A Kale	
<b>Radiology</b>	Dr S Slater	
<b>Surgery Divisional Lead</b>	Mr M Kumar	
<b>Surgery</b>	Miss P Patel	Mr T Raymond
<b>Breast</b>	Mr R Parmeshwar	
<b>Urology</b>	Mr M Naseem	
<b>Infection Prevention</b>	Angela Richards	
<b>Safeguarding</b>	Mark Lippett	
<b>Health and Safety</b>	Anna Smith	
<b>Pharmacy</b>	Laura Healey	
<b>Blood Transfusion</b>	Jill Livingston	

Table 11

## Summary

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The clinical audit team has benefitted greatly following the inception of the Clinical Audit & Effectiveness Steering Group. The team is aware of a palpable improvement in the number of clinical audit projects completed (both from the Forward Programme 2014/15 and those additional projects undertaken); the number of action plans submitted; the number of actions which have been completed within prescribed timescales. The targets set within in the CQC Recovery Action Plan for the audit area have been met, and the action plan completion for Level 1 and 2 priority projects has been exceeded.

The team would like to acknowledge the support of the Director of Clinical Governance for her ongoing support, and for the support received from her by the clinical audit leads.

It is anticipated by the team that the introduction of the Ulysses Clinical Audit Module will facilitate streamlined and comprehensive capture and reporting on all stages of the clinical audit process and that this will aid the team with the increased workload of the additional Advancing Quality projects to be introduced during 2015/16.

There is a marked improvement in the timeliness and content of the incoming Forward Programme for 2015/16. The forecast clinical audit workload within the trust, via the Forward Programme 2015/16, is set to be of a similar level to that of this year. The year 2014/15 has proved to have been a successful one and we anticipate a similar level of productivity and outcome will be reportable for 2015/16.

During 2015/16, we shall continue to improve our processes and reporting systems wherever, ensuring that we keep abreast of changes announced by the Department of Health, the Healthcare Quality Improvement Programme and the Care Quality Commission to ensure we comply with requirements and are able to respond confidently to requests for information by any external agencies, with associated evidence.

## Objectives for 2015/16

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The objectives for clinical audit for 2015/16 are outlined below:

- To develop an approved annual clinical audit forward programme, comprising of national and trust identified priorities.
- Full delivery in all national clinical audits as defined by HQIP.
- Monitor the efficacy of the Ulysses system in establishing a robust system for reporting the outcomes of clinical activity and monitoring action plans in order to measure achievement of the Key Performance Indicators (100% of Level 1 and 2 audits to have an action plan completed; 80% of these to have actions implemented within prescribed timescales) with the Trust's CQC Recovery Action Plan.
- Train and support auditing staff and Clinical Audit Leads to fully utilise the clinical audit module within the Ulysses Safeguard system, in order to monitor action plan completion, implementation and closure.
- Clinical audit and NICE compliance to be a standing agenda item at all the divisional governance forums.
- To ensure organisational compliance with national requirements such as NICE and CQC.
- To provide assurance to the Trust Board with regards to clinical audit activity and NICE compliance.
- To ensure that staff have the necessary competency and support to participate in clinical audit.
- Maintain and update specialist knowledge with changes nationally and locally.
- Liaise with Risk Management to identify key areas of concern.
- Clinical audit staff to be proactive in relations with audit leads.
- Feed into the Learning Lessons (CLIP) quarterly bulletin.
- To hold a third clinical audit awareness day on each of the trust sites.

## Process for Review and Approval of Incoming Audit Projects

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### **Forward Programme Topics**

- All projects placed on the Forward Programme should be undertaken, within the timescales outlined therein.
- Projects will range from Level 1 – Level 4 (HQIP definition).

### **Non-Forward Programme Topics:**

- High Priority Proposals: Levels 1 & 2 (HQIP definition).  
These projects will automatically be undertaken, due to their high priority.

- Lower Priority Proposals: Levels 3 & 4 (HQIP definition).  
These projects will be forwarded to the Deputy Manager / Manager for screening and escalation (see Escalation Process below).

### **Approval Process**

- Electronic proposal form is submitted to Departmental shared email account and the relevant facilitator will retrieve the submission. All staff received electronic notification of each receipt.
- Proposal form is reviewed by Clinical Audit Facilitators to ensure clear criteria, standards, start & completion date, audit methodology are clearly documented.
- Facilitators work closely with auditing clinical team to deliver support, training and advice to ensure lean and SMART (Specific, Measurable, Achievable, Realistic, Timely) parameters are defined.
- Facilitators are encouraged to seek support and advice from Deputy Manager / Manager at any stage.
- When the proposal is fully completed, it is forwarded to Deputy Manager / Manager for approval.
- Auditing team are notified of consent to proceed, as soon as possible from receipt of proposal.

### **Escalation Process**

- Deputy Manager / Manager will review the proposal and seek further information / clarification where applicable, ensuring the correct priority level has been selected.
- When sufficient clarification has been received, the proposal is forwarded to Medical Director for final opinion and / or approval.

### **Registration**

The annual Clinical Audit Register is pre-populated with all Forward Programme projects.

- High Priority Proposals: Levels 1 & 2 (HQIP definition).  
These projects will have their registration status updated once they commence and their subsequent progress will be plotted month-on-month until completion.
- Lower Priority Proposals: Levels 3 & 4 (HQIP definition).  
These projects will be entered to the Clinical Audit Register as “Additional Projects” and their subsequent progress will be plotted month-on-month until completion.

## Recommendations Made from Audits Completed 2014-15

As a result of the audits completed 2014/15 within the Trust at Divisional level, the following recommendations have been confirmed (Table 12).

<b>Table 12</b>	
<b>Local Clinical Audits presented for assurance to the Board of Directors 2014/15</b>	<b>Details of actions taken to improve the quality of local services and the outcomes of care.</b>
<b>Refusal of blood</b>	<ul style="list-style-type: none"> <li>• UHMBT legal and governance advice sought which led to the re-writing of the policy.</li> </ul>
<b>BMI hospital fridge annual audit</b>	<ul style="list-style-type: none"> <li>• Checklist re-written to include cleaning log and days of the week</li> </ul>
<b>Massive Haemorrhage Audit</b>	<ul style="list-style-type: none"> <li>• Approve revised Massive Haemorrhage policy</li> </ul>
<b>Audit of PCC Usage</b>	<ul style="list-style-type: none"> <li>• Nil actions required</li> </ul>
<b>Therapy Outcome Measure (TOM) Audit</b>	<ul style="list-style-type: none"> <li>• Train / Retrain Occupational Therapy staff to use the Therapy Outcome Measure (TOM)</li> </ul>
<b>Audit of use of discharge checklist on wards</b>	<ul style="list-style-type: none"> <li>• Liaise with pharmacy staff to remind them to provide checklists with discharges, including those done directly at ward level which do not need dispensing by pharmacy</li> <li>• Speak to ward managers at their forums regarding completion of the discharge checklist to improve front line staff awareness</li> <li>• Contact TMS co-ordinators and ward managers for those wards who have not initiated completion of the TMS module</li> </ul>
<b>Audit of clinical incident reports relating to critical medicines</b>	<ul style="list-style-type: none"> <li>• Medication Safety Bulletin issued for anticoagulants, anti-infective medications and opioids.</li> </ul>
<b>Thyroid FNA outcomes</b>	<ul style="list-style-type: none"> <li>• Introduce the new BTA guidelines with regards to radiological classification of thyroid nodules</li> </ul>
<b>Audit of all cancers detected on second screening round of screening previously returned to routine recall at prevalent round screening.</b>	<ul style="list-style-type: none"> <li>• Review of films by all film readers</li> </ul>
<b>RCR National audit 'Accuracy of interpretation of emergency abdominal CT in adult patients who present with non-traumatic abdominal pain'</b>	<ul style="list-style-type: none"> <li>• Nil action required</li> </ul>
<b>Are we compliant with NICE guidelines for imaging in CT head for trauma?</b>	<ul style="list-style-type: none"> <li>• Nil action required</li> </ul>
<b>Audit of radiographer auto-reporting</b>	<ul style="list-style-type: none"> <li>• Continue to monitor accuracy of auto-reporting by radiographers by ensuring all checks are completed daily</li> </ul>

<b>Vacuum Assisted Biopsy – A year's experience</b>	<ul style="list-style-type: none"> <li>• To perform a review of surveillance mammograms in the cohort of patients who have undergone a 7G excision biopsy to ensure there is no evidence of recurrence.</li> <li>• Ensure a clip is inserted following 7G excision as there is a potential to excise the whole lesion.</li> </ul>
<b>Audit of correlation between MRA of the Shoulder with Shoulder Arthroscopy</b>	<ul style="list-style-type: none"> <li>• Nil action required</li> </ul>
<b>Aseptic Non Touch Technique ANTT AUDIT 2014</b>	<ul style="list-style-type: none"> <li>• Individual feedback given to staff member at time of audit</li> <li>• Audit presented at cross bay clinical skills team meeting</li> <li>• Audit data shared with Clinical Skills Team to enable information sharing during workshops and during contact with staff on wards</li> <li>• Audit presented at the Infection Prevention Operational Group (IPOG)</li> <li>• ANTT Update sessions being delivered to key trainers. Audit presented during these sessions</li> <li>• Audit presentation and report sent to ward based ANTT key trainers/ practice educators/ infection prevention team FGH</li> <li>• Report and presentation published to Intranet</li> <li>• "Scrub the Hub" poster campaign. Laminated posters sent to ward based key trainers at FGH</li> <li>• ANTT E-learning programme to be updated</li> </ul>
<b>Cannula spot check audit FGH</b>	<ul style="list-style-type: none"> <li>• Documentation to be standardised across the trust</li> <li>• Vascular access escalation policy produced</li> <li>• Vascular access team business case developed</li> <li>• Cannulation Indication check list developed</li> <li>• Re Audit of cannulation yearly</li> <li>• Development of Patient Information leaflet</li> </ul>
<b>Nursing Documentation Audit</b>	<ul style="list-style-type: none"> <li>• Identify areas of good practice which could be used as a model for future nursing documentation</li> <li>• Task and finish group to;</li> <li>• Undertake a review of the "Safety Bundle" and Intentional Rounding Tool to ensure they are fit for purpose</li> <li>• Agree revised assessment documentation</li> <li>• Arrange new printing run</li> <li>• Agree an interim standard for nursing documentation to reduce variation across the Trust and improve patient safety</li> <li>• Arrange to discuss the possibility of expediting the development of an E Nursing document as soon as possible</li> </ul>

	<ul style="list-style-type: none"> <li>• Arrange a “safer standards for nursing documentation workshop” with ward managers and matrons to feedback audit results and agree a Trust wide standard for nursing documentation</li> <li>• Include a programme of regular audits of nursing documentation within the new Nursing and Midwifery Quality Assurance Framework – RAISE, NAAS</li> </ul>
<b>Urology Attendance in A&amp;E</b>	<ul style="list-style-type: none"> <li>• Ask Urology team to draw up a management pathway for patients with catheters, to improve communication between primary and secondary care</li> <li>• Present or send the audit results to the ‘Better Care Together Team’ to facilitate improved liaison between primary and secondary care</li> </ul>
<b>Audit on assessment of delirium in acute medical admissions to FGH in patients over 65 years</b>	<ul style="list-style-type: none"> <li>• Increase awareness of the importance of delirium screening, with posters in key areas (design and display posters in areas of maximum effect, e.g. Dr’s office MAU)</li> <li>• Make the 4AT forms easily available in MAU and A&amp;E, to be included with the clerking package</li> <li>• Improve rates of confusion screening with reminders to first check for, then find a, cause for confusion (design and display posters in areas of maximum effect, e.g. Dr’s office MAU)</li> <li>• Re-auditing this in the next 2 months to see if there has been any improvement will also raise the issue again and help improve awareness in the next cohort of doctors coming into the trust</li> </ul>
<b>Acute Kidney Injury Audit 2014</b>	<ul style="list-style-type: none"> <li>• Identification of patients at risk of developing AKI (poster with AKI risk factors in MAU and wards, education of nurses and doctors)</li> <li>• Documentation of cause and Details of AKI (education of doctors)</li> <li>• Staging of AKI (as above)</li> <li>• 100% monitoring of urine output in patients with AKI (education of nurses, and HCSW)</li> <li>• AKI bundle (education of health support workers, nurses and doctors)</li> <li>• Reduce readmission (patient education/family. Patient advise note to avoid certain drugs that are nephrotoxic, if unwell or dehydrated)</li> </ul>
<b>Acute Kidney Injury Re-Audit 2014</b>	<ul style="list-style-type: none"> <li>• Training on early referral of appropriate patients to the nephrologist: e-alert, referral criteria, staff education on referral criteria and use of NORSe (National On-call Referral Service electronic, AKI). To organise appropriate training for all staff</li> <li>• Appointment of AKI specialist nurses and AKI ward champions to support ward nurses in implementing AKI care</li> <li>• Update of fluid balance chart with implementation triggers</li> </ul>

	<ul style="list-style-type: none"> <li>AKI Bundle to ensure - daily documentation of hydration status, EWS, fluid balance, fluid prescription and medication review, renal function, staging and criteria for referral by the consultant or registrar</li> <li>Improved TTO to include information to GP about AKI stage, medication adjustment, when to review patient, when to repeat renal function and how often, when and how to reintroduce some stopped medications</li> </ul>
<b>Management of Chest Pain on AMU</b>	<ul style="list-style-type: none"> <li>Nil action required</li> </ul>
<b>Quality &amp; Safety indicators of Colonoscopy/Flexible Sigmoidoscopy procedure</b>	<ul style="list-style-type: none"> <li>To investigate and improve bowel preparation (To liaise with patient specific data, i.e. need to contact Endobase)</li> </ul>
<b>30 Day Mortality Post-Endoscopic Procedures</b>	<ul style="list-style-type: none"> <li>Review data of deceased without cause</li> <li>Re-analyse and re-present finding at next audit meeting</li> <li>We should use less sedation in combination with throat spray (Individual case by case assessed by individual endoscopists)</li> </ul>
<b>8 day readmission post endoscopy</b>	<ul style="list-style-type: none"> <li>Re audit</li> </ul>
<b>Alcoholic Liver Disease</b>	<ul style="list-style-type: none"> <li>All patients admitted with alcohol dependence should be treated according to NICE guidelines.</li> <li>All patients should receive oral <u>chlordiazepoxide</u> to prevent alcohol withdrawal seizures and delirium treatment.</li> <li>All patients should receive IV multi-vitamins with paprinex for 3 days – additional use of quetiapine should be considered in all patients discharged from hospital.</li> <li>Disulfiram (Antabuse) can be used in patients at risk of relapse.</li> <li>In this audit the clinical incident withdrawal assessment (CIWA) tool was used measuring 10 symptoms. This tool would be helpful in monitoring patients and is not routinely used but should be introduced and placed with librium form in MAU</li> <li>Inpatients should be referred to drug and alcohol liaison teams for outpatient f/up.</li> <li>Mental health teams should be informed of patients with severe or suicidal ideation.</li> <li>Hopeful appointment of Drug &amp; Alcohol Nurse Practitioner at FGH to create similar staffing structure to that at RLI</li> </ul>
<b>INR &gt;8 in patients on warfarin</b>	<ul style="list-style-type: none"> <li>Email to relevant staff in the laboratory to remind them of the importance of INR&gt;8.0 being informed to medical staff within 1 hour of result being available</li> <li>Email BCSH guideline to all relevant medical staff to increase the compliance of treatment</li> <li>Email to medical staff for the prompt treatment in order to minimise the time between the haemorrhagic presentation and treatment given</li> </ul>



<b>Annual audit of completeness of excision of basal cell carcinoma</b>	<ul style="list-style-type: none"> <li>• Nil action required</li> </ul>
<b>The use of adalimumab, etanercept and infliximab in Ankylosing spondylitis patients</b>	<ul style="list-style-type: none"> <li>• Improved documentation of qualifying factors for biologic therapy. (Use the suggested documentation sheet to insert into all patients notes).</li> </ul>
<b>An audit of DAS28 documentation in rheumatology outpatients</b>	<ul style="list-style-type: none"> <li>• To clearly state the components and if possible the DAS28 score in patients with inflammatory arthritis</li> </ul>
<b>Audit on the use of the Oncotype DX testing at Morecambe Bay Hospital Trust and assessment on impact in the management of patients with ER+, LN-, Her-, early breast cancer</b>	<ul style="list-style-type: none"> <li>• Nil action required</li> </ul>
<b>Quality of two-week-wait referrals for Malignant Melanoma</b>	<ul style="list-style-type: none"> <li>• Prepare presentations and collect appropriate clinical and Dermoscopy pictures of melanoma</li> <li>• Perform excisions on the first seen date - minimize time for Pathology processing of the specimen and result report</li> </ul>
<b>Re-audit of heart failure</b>	<ul style="list-style-type: none"> <li>• Use NHYA or more descriptive classification to assist with severity grading</li> <li>• All patients with heart failure should see a member of the heart failure team on each admission</li> </ul>
<b>An audit on the consideration of organ donation after withdrawal of treatment and the use of the Withdrawal of Care Pathway on the Intensive Care Unit at the Royal Lancaster Infirmary</b>	<ul style="list-style-type: none"> <li>• Increased use of the Withdrawal Pathway on ICU to inform importance and appropriateness of organ donation</li> <li>• Improve referral rate to the Organ Donation team when patients are having active withdrawal considered</li> <li>• Improve family consent rates. Increase SNOD involvement to improve rates. Increase organ donation rates</li> </ul>
<b>Pre-operative ECHO</b>	<ul style="list-style-type: none"> <li>• Further training for pre-operative nurses in order to facilitate improved referral of patients from the Pre-operative Clinic</li> </ul>
<b>Telephone follow up audit of day case laparoscopic surgery</b>	<ul style="list-style-type: none"> <li>• Highlight requirement for day case surgery to be performed in the morning theatre sessions</li> <li>• Update and distribute advice leaflets</li> <li>• Update the Anti-emetic Protocol</li> </ul>
<b>Management of dural puncture headache</b>	<ul style="list-style-type: none"> <li>• Submit results for publication in national journal</li> <li>• Continuous audit of post-dural headaches</li> <li>• Follow-up post-dural headache cases in the Obstetric Anaesthetic Clinic</li> <li>• Highlight lack of FGH audit of cases</li> <li>• Highlight lack of FGH follow-up of cases</li> </ul>
<b>RCOA standard 8.5- Audit of antacid prophylaxis in labour</b>	<ul style="list-style-type: none"> <li>• Inform obstetricians and midwives on audit and that opiates in labour should trigger ranitidine prescription</li> <li>• Re-audit</li> </ul>
<b>Adequacy of anaesthetic staffing RLI and FGH</b>	<ul style="list-style-type: none"> <li>• Business plan submitted for better anaesthetic staffing</li> <li>• Revised plan submitted May 2015</li> <li>• Place on trust register</li> </ul>

	<ul style="list-style-type: none"> <li>• Inform Chief Executive Officer and Clinical Commissioning Groups</li> </ul>
<b>Audit of Anaesthetic Involvement in Obstetric Patients with a BMI &gt; 40</b>	<ul style="list-style-type: none"> <li>• Review leaflets and liaise with risk midwives to ensure appropriate information given to all patients with BMI&gt;30</li> <li>• Clarify the referral criteria to OAC from ANC and update guideline. Exclude previous normal vaginal deliveries and previous Obstetric Antenatal Clinic appointment</li> <li>• Ensure routine handover of any patients with BMI&gt;40 to anaesthetist on call</li> <li>• Disseminate information via Lessons Learned document</li> </ul>
<b>Prescribing for enhanced recovery arthroplasty surgery</b>	<ul style="list-style-type: none"> <li>• Ensure guidelines are stored within the Heritage system</li> </ul>
<b>ICU Documentation Audit</b>	<ul style="list-style-type: none"> <li>• Introduce electronic documentation, recorded in Lorenzo</li> <li>• Daily review proforma is available as a template in Lorenzo</li> <li>• Re audit for FY2 in ICU</li> </ul>
<b>Theatre Over run at FGH</b>	<ul style="list-style-type: none"> <li>• To discuss with Theatre Manager that anaesthetic time should be included on ORMIS for the theatre list</li> </ul>
<b>Pain relief post c/section under regional anaesthetic</b>	<ul style="list-style-type: none"> <li>• Pain relief should be discussed with the patient</li> <li>• Use routinely diamorphine intrathecally or equivalent in the epidural space</li> <li>• Encourage the use of NSAID if there is no contraindications</li> </ul>
<b>Caesarean Section Anaesthetic Technique (GA vs RA)</b>	<ul style="list-style-type: none"> <li>• Present results as part of educational session to joint RLI/FGH anaesthetic audit meeting</li> <li>• Reaudit after education</li> <li>• Communicate concern re high category 1 section rate to anaesthetic, midwifery and obstetric leads and lead WACS division</li> </ul>
<b>Assessing efficacy of radiofrequency procedure for sacro-iliac joint pain</b>	<ul style="list-style-type: none"> <li>• New patients having procedure performed will be added</li> <li>• to database at appropriate follow up dates</li> </ul>
<b>Vygon needle audit</b>	<ul style="list-style-type: none"> <li>• Replace existing needle once existing stock used up</li> <li>• Baseline audit of existing epidural needles</li> <li>• Re-audit once new Vygon needles stock in use</li> </ul>
<b>Waiting Time for Results</b>	<ul style="list-style-type: none"> <li>• Re-audit in 2015 and compare findings</li> </ul>
<b>Breast Audit - Day case and one night stay</b>	<ul style="list-style-type: none"> <li>• Re-audit cases from the same period in 2014/2015</li> <li>• Include patient experience of their discharge</li> <li>• Breast Care Nurses to collect information when telephoning patient day after discharge. To audit the findings</li> <li>• Currently working alongside Lorenzo team to introduce</li> <li>• the new waiting list proforma which will be completed</li> </ul>

	<p>electronically</p> <ul style="list-style-type: none"> <li>• Need to ensure the option of being able to select day case and one night stay</li> <li>• Forward the Day case audit to the Ward managers. Meet and discuss in the next ward meeting</li> </ul>
<b>Re-excision Rate for Breast-conserving Surgery</b>	<ul style="list-style-type: none"> <li>• Nil action required</li> </ul>
<b>Mastectomy Rate</b>	<ul style="list-style-type: none"> <li>• Nil action required</li> </ul>
<b>24 Hour letter to GP (RLI)</b>	<ul style="list-style-type: none"> <li>• Clinicians to follow 24 hour pro-forma to dictate letters to GP's. Discuss with Secretaries</li> </ul>
<b>Waiting time for adjuvant treatment</b>	<ul style="list-style-type: none"> <li>• Need to improve waiting times for Radiotherapy. To discuss with the Oncologists</li> </ul>
<b>Re-audit keyworker sticker in patients notes</b>	<ul style="list-style-type: none"> <li>• Keyworker stickers to be attached to MDT pro-forma in MDT for them to be available to be stuck in the case notes at the time of the patients results/consenting appointments</li> </ul>
<b>Care plan audit</b>	<ul style="list-style-type: none"> <li>• Agreed that all clinicians and BCN's need to use the care plan database which is populated prospectively in each MDT meeting and only requires some additional information inputting before given to the patients</li> <li>• This will be monitored on a monthly basis to assess individual clinicians performance</li> <li>• Re-audit in 2015</li> </ul>
<b>Trans-abdominal Pre-peritoneal (TAPP) Laparoscopic Hernia Repair of Inguinal Hernia at FGH</b>	<ul style="list-style-type: none"> <li>• Continue to adhere to NICE guidance for TAPP inguinal hernia repair</li> <li>• Consider audit of pain control in laparoscopic vs open Repair</li> <li>• Study of patient preferences</li> <li>• Audit of early recurrence / complications in laparoscopic vs open repair</li> </ul>
<b>Retrospective audit of Hartmann's Procedure</b>	<ul style="list-style-type: none"> <li>• All patients undergoing Hartmann's procedure should have risk prediction in surgery carried out using pPOSSUM</li> </ul>
<b>Re-audit of Head injury management</b>	<ul style="list-style-type: none"> <li>• Highlight importance of clear and thorough documentation in patients with head injuries</li> <li>• Ensure that staff know NICE guidelines on when to admit patients with head injuries, to prevent unnecessary cost burden</li> <li>• Emphasize importance of relaying both written and verbal head injury advice to patients and documenting this in notes.</li> </ul>
<b>Mortality and Morbidity Outcomes of Emergency Cholecystectomy</b>	<ul style="list-style-type: none"> <li>• Look at the cases of conversion and find out pathology</li> <li>• Management of the acute cholecystitis (conservative and surgical) and its outcome. (RE-AUDIT)</li> </ul>
<b>Are we Adhering to the Sepsis 6?</b>	<ul style="list-style-type: none"> <li>• Organise a session on sepsis for junior doctors</li> </ul>
<b>Laparoscopic Appendectomy Audit under one surgeon</b>	<ul style="list-style-type: none"> <li>• No actions required</li> </ul>
<b>Surgical Note-keeping Audit</b>	<ul style="list-style-type: none"> <li>• Give presentation to postgraduate doctors regarding results of audit</li> </ul>

	<ul style="list-style-type: none"> <li>• Produce checklist to put on notes covers</li> <li>• Distribute the checklist to wards 4&amp;5</li> </ul>
<b>Regular medication prescribing audit</b>	<ul style="list-style-type: none"> <li>• 15 minute short lecture / discussion with FY1 / FY2 regarding taking a thorough medication</li> <li>• history and the importance of filling in the clerking document</li> <li>• Create feedback forms for pharmacy and nurses highlighting the main pitfalls and mistakes</li> <li>• made by junior doctors regarding prescribing regular medications</li> <li>• Meeting with lead pharmacist and creating access for all doctors to the GP's list of the patients</li> <li>• regular medications</li> </ul>
<b>Audit of referrals to OMFS department for release of ankyloglossia</b>	<ul style="list-style-type: none"> <li>• Education of all staff who refer patients with suspected ankyloglossia to OMFS Department</li> <li>• Setting up of new Ankyloglossia Clinic in LRI</li> <li>• Repeating the audit cycle</li> </ul>
<b>BAOMS National Mandible Fracture: time to theatre audit 2014</b>	<ul style="list-style-type: none"> <li>• Monitor that patient with fractured mandibles are treated by end of next working day</li> <li>• Check if increased rate of infection for those who are delayed</li> </ul>
<b>Diabetic Screening Letter Tool</b>	<ul style="list-style-type: none"> <li>• Distribution of information tool</li> </ul>
<b>Cataract complication audit</b>	<ul style="list-style-type: none"> <li>• To commence a book to document the post op complications that are noted at the post –op visit. This is now in place on all sites.</li> </ul>
<b>Audit of the practice of YAG laser capsulotomy undertaken at RLI</b>	<ul style="list-style-type: none"> <li>• To circulate new grading guidelines to all doctors involved in grading referrals</li> <li>• Ancillary actions include evidence based discussion of post-operative drops following laser capsulotomy as an educational session</li> </ul>
<b>Orthoptic Management Of New Referral Paediatric NAD's</b>	<ul style="list-style-type: none"> <li>• We need to standardise our practice, with regard to refraction and in line with Ophthalmology, to provide equitable service across the Trust</li> <li>• Review action plans and progress in 12 month time</li> </ul>
<b>Medical records in ophthalmology</b>	<ul style="list-style-type: none"> <li>• None needed as now going paperlite</li> </ul>
<b>Compliance with the Enhanced Recovery Pathway for Orthopaedics</b>	<ul style="list-style-type: none"> <li>• No actions required</li> </ul>
<b>Use and Abuse of X-ray Radiation in Theatre</b>	<ul style="list-style-type: none"> <li>• Liaise with radiology department for accurate documentation of DAP on every fluoroscopic procedures</li> <li>• Re-audit</li> </ul>
<b>VTE prophylaxis in fracture neck of femur patients</b>	<ul style="list-style-type: none"> <li>• Implement the use of the VTE NICE guideline checklist across all adult inpatients</li> </ul>
<b>Trauma Workload Over The Weekend- Do We Need Dedicated Trauma Lists? Audit</b>	<ul style="list-style-type: none"> <li>• Prospective audit over 4 month period of all weekend orthopaedic admissions and time to surgery with any reasons for delay/cancellation documented.</li> </ul>
<b>Neck of Femur- Delays to theatre</b>	<ul style="list-style-type: none"> <li>• Monitor time to theatre for neck of femur patients on an ongoing basis – plan more theatre availability during busy summer months</li> </ul>
<b>Elective Orthopaedic Productivity</b>	<ul style="list-style-type: none"> <li>• Minimum of 10 patients for joint surgery each week</li> </ul>

	<ul style="list-style-type: none"> <li>• Ensure lists are filled each week and theatre lists are reutilised when Consultants are on annual leave. Bed utilisation will be assessed at 1pm each day to assess performance.</li> </ul>
<b>Consultant ward rounds at FGH</b>	<ul style="list-style-type: none"> <li>• Encourage ward sisters on wards 4 and 5 to join the ward rounds</li> </ul>
<b>ESWL</b>	<ul style="list-style-type: none"> <li>• CT scan for all patients before ESWL</li> <li>• Less than 4 mm stone do not need Treatment</li> </ul>
<b>Cumbria Audit Tool to Monitor Safeguarding Standards</b>	<ul style="list-style-type: none"> <li>• There is a process for resolving cases where health professionals have a difference of opinion in relation to safeguarding concerns for children and vulnerable adults</li> <li>• There is clear guidance on managing allegations against staff and volunteers working with children and vulnerable adults in line with those of the guidance of the LSCB and LSAB</li> <li>• There is clear guidance to support front line professionals on the identification of and response to Female Genital Mutilation (FGM)</li> <li>• The provider complies with the principles in Prevent and the Prevent guidance toolkit</li> <li>• Pathways are in place to ensure safeguarding during transition to adult services are met. There are processes in place to specifically address the transition of children to adult services- clear pathways in place to ensure continuous safe transfer of services/ care</li> <li>• A strategy in place in accordance with the management of Child sexual exploitation national guidance</li> <li>• There is clear guidance for dealing with children, young people and adults who are at risk of domestic violence, and for recognising /acting on concern</li> <li>• Requirement to work from single set of records for a child when professionals are working within a given location</li> <li>• Training for MCA / DOLS</li> <li>• There is clear guidance as to the discharge of adults for whom there are safeguarding and protection concerns.</li> </ul>
<b>Ovarian cancer CG122 April 2011</b>	<ul style="list-style-type: none"> <li>• To ensure all women less than 40yrs of age have tumor markers AFP/LDH and Bhcg done</li> </ul>
<b>Audit of Outpatient Hysteroscopy</b>	<ul style="list-style-type: none"> <li>• Use this audit to support the business case to purchase the Myosure device (business case for this was already submitted)</li> </ul>
<b>Vaginal Birth After Caesarean</b>	<ul style="list-style-type: none"> <li>• All women with previous CS should offered VBAC unless contraindicated.</li> <li>• An ECV sticker/porforma should be available in antenatal clinic and should be filled in all cases of breech</li> </ul>

	<ul style="list-style-type: none"> <li>• presentation at 36 weeks without uterine scar</li> <li>• Weekly review in our every Monday CS meeting of emergency CS for fetal distress to ensure that FBS had been done whenever appropriate</li> <li>• Adding FBS to our emergency CS data collection proforma</li> <li>• To discuss with Guideline group regarding having clear trust policy for patients asking for elective CS without clear medical or obstetric indications</li> </ul>
<b>Antenatal hand held notes Audit 2014</b>	<ul style="list-style-type: none"> <li>• Commence monthly audit on hand held notes across all 3 sites</li> <li>• Modify current data collection tool as appropriate – cascade to community managers for dissemination to appropriate staff</li> <li>• Present findings to senior meeting</li> </ul>
<b>Caesarean Section Classifications 1 &amp; 2 FGH</b>	<ul style="list-style-type: none"> <li>• Improve compliance in completing audit proformas</li> <li>• Audit form to be added to Lorenzo</li> <li>• Ensure all Midwives/Doctors/ Theatre team are all aware that Grade 1 C/section can proceed straight to theatre without waiting for call ( unless theatre 3 already in use)</li> <li>• Improve documentation surrounding Caesarean Section</li> <li>• Reasons for not meeting DDI must be recorded and incident form created</li> </ul>
<b>Caesarean Section Antibiotic Administration</b>	<ul style="list-style-type: none"> <li>• All women undergoing a caesarean section should be given prophylactic antibiotics of 1.2g IV Augmentin before skin incision provided there is no history of sensitivity to penicillin – this should be clearly prescribed and signed on the prescription chart as per UHMBT prescription record guidelines</li> <li>• To email anaesthetists to ask if they can record antibiotics given on the prescription sheet instead of the anaesthetic record and clearly record reason if antibiotic is not given. To enable MW and Drs to clearly identify type of antibiotic and time of administration</li> <li>• To Re-audit in March 2015 – aim to complete and present in April 2015</li> </ul>
<b>Induction of Labour</b>	<ul style="list-style-type: none"> <li>• To commence audit of medical staff record keeping – D/W Mr Sinha to wait until new notes become established into practice prior to audit</li> <li>• ANC staff to ensure all women booked for IOL are given written information and this is clearly documented within the ANC notes – maternity/labour ward staff to ensure woman has received written information prior to IOL commencing. Already discussed at the audit meeting. Amanda to discuss with A Sambrook the feasibility of developing a sticker checklist to put in notes once induction is decided and if so –how to take this forward</li> </ul>



	<ul style="list-style-type: none"> <li>• Remind staff via WACS bulletin</li> <li>• Stretch and Sweep to be offered to all women prior to IOL as per guideline with the exception of pre labour SROM</li> <li>• Re-audit in 3/12</li> </ul>
<b>Audit of Recordkeeping Intrapartum Notes Cross Bay July 2014</b>	<ul style="list-style-type: none"> <li>• Escalate to matrons/managers to develop action plan</li> <li>• Monthly self-audit on Intrapartum / Postnatal Mother and baby notes for all midwives as mandatory to promote personal development within record keeping – as part of supervisory/KSF</li> <li>• Liaise with education dept. to commence staff training on completion of maternity notes – to incorporate current MW'S, new starting MW's, student mw's. discussed at Seniors meeting to have another mandatory study day around record keeping/accountability incorporated into next year's education programme</li> <li>• Advise MW's via monthly news re requirement to document signposting of patient information/health promotion with signature and date</li> <li>• Re-audit notes once changes implemented</li> </ul>
<b>Baby Postnatal Notes</b>	<ul style="list-style-type: none"> <li>• Escalate to matrons/managers to develop action plan</li> <li>• Monthly self-audit on Intrapartum/Postnatal Mother and baby notes for all midwives as mandatory to promote personal development within record keeping – as part of supervisory/KSF</li> <li>• Liaise with education dept. to commence staff training on completion of maternity notes – to incorporate current MW'S, new starting MW's, student mw's</li> <li>• Discussed at Seniors meeting to have another mandatory study day around record keeping/accountability incorporated into next year's education programme</li> <li>• Advise MW's via monthly news re requirement to document signposting of patient information/health promotion with signature and date</li> <li>• Re-audit notes once changes implemented</li> </ul>
<b>Eclampsia/Pre-Eclampsia</b>	<ul style="list-style-type: none"> <li>• Discussion at the audit meeting led to a request to pharmacy re considering the possibility of using pre filled syringes for the loading dose of magnesium sulphate</li> <li>• Instillation of emergency box to FGH theatre</li> <li>• Add checking of emergency kit to labour ward checking system</li> <li>• Check MgSO4 kits available in ICU and A&amp;E on both sites (RLI,FGH)</li> </ul>
<b>Shoulder Dystocia</b>	<ul style="list-style-type: none"> <li>• Ensure paediatricians are alerted by 2222 in all cases of shoulder dystocia</li> <li>• To be reiterated in mandatory study prompt days</li> </ul>

	and via WACS email to all staff
<b>Perineal Trauma</b>	<ul style="list-style-type: none"> <li>• Ensure all the postoperative parts of the standards such as debrief, leaflet, consultant follow-up 3/12 are included within the audit as discussed in the presentation</li> <li>• Ensure Swab counts are completed – signed and countersigned on the appropriate pages in the birth notes by the appropriate staff involved.</li> </ul>
<b>Emergency Transfers</b>	<ul style="list-style-type: none"> <li>• Devise and introduce a new transfer audit proforma to be completed for all transfers</li> <li>• Introduce an elearning module /education session regarding reporting clinical incidents</li> <li>• Liase with ambulance service to clarify category of transfer times according to NNAS</li> </ul>
<b>VTE Assessment Tool</b>	<ul style="list-style-type: none"> <li>• Continue to disseminate VTE power point to new starting doctors and midwives to promote correct VTE assessment</li> <li>• Ask new starting Doctors/Midwives to complete VTE audit to facilitate learning how to correctly complete VTE form</li> </ul>
<b>CTG Recordkeeping</b>	<ul style="list-style-type: none"> <li>• Discuss with ward managers re communication to staff at ward meetings/hand over</li> <li>• All midwives now have a 'stamp with printed name and PIN number for ease of identification</li> <li>• PIN numbers available for all Drs.</li> </ul>
<b>Prescription Chart Audit</b>	<ul style="list-style-type: none"> <li>• Ensure all new Doctors and Midwives within the trust complete 5 prescription chart audits and are familiar with local guidelines on the administration of medicines</li> <li>• Include audit findings in mandatory study day and lessons learnt to reiterate record keeping requirements with prescribing and administration of medicines</li> </ul>
<b>Action Plan to reduce CS rate based on the results of: “ Previous CS Audit”</b>	<ul style="list-style-type: none"> <li>• All women with previous CS should be referred to previous CS clinic unless contraindicated</li> <li>• An ECV sticker/proforma should be available in antenatal clinic and should be filled in all cases of breech presentation at 36 weeks without uterine scar</li> <li>• Weekly review in our every Monday CS meeting of emergency CS for fetal distress to ensure that FBS had been done whenever appropriate</li> <li>• Adding FBS to our emergency CS data collection proforma</li> <li>• To discuss with Guideline group regarding having clear trust policy for patients asking for elective CS without clear medical or obstetric indications.</li> </ul>
<b>Local RLI Paediatric Asthma Audit (using BTS paediatric asthma audit tool in line with previous BTS national asthma audit project )</b>	<ul style="list-style-type: none"> <li>• Continue to give every child and their carers a wheeze / asthma action plan on discharge from the ward, assessment unit, or in outpatients</li> <li>• To deliver at least biannual asthma training to</li> </ul>



	<p>medical staff Cross Bay, and ongoing regular nursing staff training on the frontline</p> <ul style="list-style-type: none"> <li>• To continue to participate in regular paediatric asthma audits even though national audit may not continue</li> </ul>
<b>Transition Audit</b>	<ul style="list-style-type: none"> <li>• To continue to utilise the Ready Steady Go tool for young people with long term conditions who will go through the transition process from children's to adult services.</li> </ul>
<b>Atopic eczema in children</b>	<ul style="list-style-type: none"> <li>• The atopic eczema in children will be shared with the Dermatology dept in order to address the recommendations on appropriate documentation of management of children</li> <li>• Re-audit the management of children with atopic eczema. An intermediate grade Dr will be identified to do this during the 6 month paediatric rotation commencing August 2015</li> <li>• Liaise with IT about coding diagnoses made in the outpatient dept. The audit identified that it was not possible to use the coding system to obtain patients for the audit</li> </ul>
<b>Community Acquired Pneumonia in Children (BTS)</b>	<ul style="list-style-type: none"> <li>• Increase awareness of BTS guideline – presentation of audit data KIDS day (WACS audit day)</li> <li>• On-going engagement with BTS national audit Cross-Bay + local audit (6 months period ,national Paediatric Pneumonia audit not due for 2015/2016)</li> <li>• Develop guidance which could be part of integrated Pathways – Better Care Together</li> <li>• BTS recommendations to be embedded within the Paediatric Antibiotic guidance</li> </ul>
<b>Diabetes Transition Audit</b>	<ul style="list-style-type: none"> <li>• Discuss with adult (Cumbria Diabetes) colleagues regarding Psychology cover for the Transition clinic</li> <li>• Reaudit after 1 year as there will then be more young people going through the transition process</li> <li>• Carry out a patient satisfaction questionnaire to find suggestions for ways to improve attendance</li> </ul>
<b>Audit of the use of UK-WHO Growth Charts at Neonatal Units of RLI &amp; FGH</b>	<ul style="list-style-type: none"> <li>• Presenting the audit result at FGH and RLI</li> <li>• Doctors of all grades and neonatal nurse representative should attend at both sites</li> <li>• New junior doctors and middle grades should be shown growth charts and given instructions how to use them as part of baby checks induction (Dr Abuzgia &amp; Dr Fedee)</li> <li>• Growth chart should be a routine part of neonatal admission and clerking process (Dr Abuzgia at FGH and Dr Fedee at RLI)</li> <li>• Re-audit every 12 months</li> <li>• Close monitoring charts to be made available at FGH neonatal unit</li> </ul>
<b>Self-harm in Children</b>	<ul style="list-style-type: none"> <li>• Request that all children assessed in A&amp;E to be seen in the paediatric assessment room, as long as child is</li> </ul>

	<p>accompanied by mother or responsible adult</p> <ul style="list-style-type: none"> <li>• Targeted training of nurses in the assessment of a child who has self-harmed so that e.g. one nurse per shift has been trained to do so</li> <li>• Present audit to CAMHS department so that they are aware of the issues we are facing and discuss how we can work together to reduce patient waiting time</li> <li>• Consider a child mental health proforma or similar (?CAF) which will include robust consideration of social history (e.g. parental separation, smoking/alcohol/drug use, parental employment, school year, forensic history and history of personal violence/abuse)</li> <li>• Department teaching in 2015 on how to assess capacity in children of different ages</li> <li>• All parents to remove medications and other means of self-harm, and written documentation of discussion</li> <li>• Consider multi-agency involvement in all cases, e.g. informing school nurse</li> </ul>
<b>Audit of Initial Management of Newly Diagnosed Type 1 Diabetic</b>	<ul style="list-style-type: none"> <li>• Height should be measured in all patients and growth should be plotted on the centile charts in every case</li> <li>• All investigations mentioned in the guideline should be done in all cases</li> <li>• Starting total daily dose of subcutaneous insulin should be 0.5 units/kg/day</li> <li>• 24 hour access to care should be documented in all cases</li> <li>• Follow up with all professionals should be documented in notes</li> <li>• Maintain areas of good practice</li> </ul>
<b>Diabetic Ketoacidosis Audit</b>	<ul style="list-style-type: none"> <li>• Make blood ketone stick available on ward</li> <li>• Be careful with fluid bolus</li> <li>• If <math>\geq 30\text{ml/Kg}</math> – seek further expert help</li> <li>• Initial fluid after resuscitation - always 0.9% saline with KCL</li> <li>• Assessment of dehydration – NOT more than 8%</li> <li>• continue Long Acting Insulin</li> <li>• Regular training regarding DKA management</li> <li>• Availability of instructions for preparation of fluid with higher glucose concentration</li> </ul>

Table 12

## Activity from Forward Audit Programme 2014/15 -vs- 2015/16

### Forward Audit plan 2015/16

This table (Table 13) summarises the number of clinical audits on the Clinical Audit Forward Plan for 2015-16 provided by the Clinical Audit Department in collaboration with the clinical audit specialty leads and divisions compared to 2014/15.

Division	2014/15	2015/16
<b>Core Clinical Services</b>		
Allied Health Care Professionals	0	3
Blood transfusion	1	10
Dietetics	3	3
Medicines Management	14	18
Pathology	0	9
Radiology	13	11
<b>Corporate / Nursing</b>		
Clinical Skills	2	1
Nursing	0	1
<b>Acute Medicine and Elective Medicine</b>		
A&E	7	5
Acute	5	2
Elective	26	25
<b>Surgery and Critical Care</b>		
Anaesthetics & Critical Care	45	37
Breast surgery	9	10
ENT	7	6
Maxillofacial	9	7
Ophthalmology	9	10
Orthoptics	0	1
Orthopaedics	17	23
General surgery	20	13
Urology	10	17
<b>WACS</b>		
Obstetrics and Midwifery	42	40
Gynaecology	6	5
Paediatrics	19	13
Safeguarding	7	7
<b>Quality &amp; Governance</b>		
Health & Safety	Not previously included in Clinical Audit Programme	14
<b>Total</b>	<b>281</b>	<b>291</b>

Table 13